Health Insurance Reform Commission
Meeting Summary
October 16, 2018
Richmond, Virginia

The Health Insurance Reform Commission (HIRC) conducted its third meeting of the 2018 interim in the House Committee Room in the Pocahontas Building on October 16, 2018. Eight members were present: Delegate Kathy Byron, chair; Senator Frank Wagner, vice-chairman; Senator Roslyn Dance; Senator Ryan McDougle; Delegate Eileen Filler-Corn; Delegate Lee Ware; Commissioner of Insurance Scott White; and Marvin Figueroa, designee of Secretary of Health and Human Resources Daniel Carey.

Surprise Balance Billing: Staff Update

Surprise balance billing is the unexpected billing of an insured patient by an out-of-network health care provider for the difference between the provider's total charges and the amount the patient's health carrier pays to the provider. Such billing for the balance of the provider's charges is a surprise when the patient was unaware that the provider was outside of the patient's insurance network, as in the situation of a patient who goes to an in-network hospital for emergency services but learns later that a treating physician was out of network. Balance billing a patient is not allowed when the provider has contracted with the health carrier to participate in the carrier's network, but state law does not bar an out-of-network provider from pursuing the patient for the balance (except in certain cases involving health maintenance organizations). At the HIRC's prior meeting, interested parties were asked to meet and determine if they could develop a solution that would protect patients from surprise balance billing.

The Bureau of Insurance (BOI) arranged the first meeting of interested parties on August 13, 2018, at the Tyler Building. After a spirited discussion, it was suggested that a few representatives of the health insurers and providers meet on their own. Representatives of health carriers and health care providers subsequently met three times. A second meeting of the "full" group of stakeholders was held on October 15, 2018.

Staff reported that as of the conclusion of the October 15 meeting the interested groups have made a great deal of progress but have not reached an agreement on all issues. The carriers and the providers agreed in concept on resolutions to situations involving non-emergency services provided by out-of-network providers. Such non-emergency situations include the sending of an insured patient's sample (such as a blood sample or x-ray) by an in-network provider to an out-of-network facility for testing or analysis without the insured patient's knowledge or approval. Under the conceptual agreement, the patient would be held harmless for any balance if there was full disclosure that the services may be provided by an out-of-network provider and the patient attested to be responsible for any balance remaining after the carrier's payment. While the parties agreed to continue working to develop a satisfactory statutory text, they acknowledged that there are many complexities and the "devil is in the details."

The majority of the discussion focused on the situation in which an insured patient receives emergency services from an out-of-network provider. Both the providers and the carriers stated they seek a system that allows prompt, seamless payment of fair reimbursement for services and that does not involve the patient. They agree that surprise balance billing should end, though billing would be allowed for copayments and other cost-sharing obligations. However, the

parties do not agree on a major question: How much should an out-of-network provider be reimbursed by the patient's insurer for its medical services?

In addressing this question of determining fair reimbursement, some states that have adopted legislation provide for mediation (Texas), and some states require the use of formulas, such as payment based on the average in-network rate paid by the insurer in a region, a percentage above Medicare's rate (California), or a percentage of all charges for health care services per a medical bill database (New York). Some states have adopted both a formula and a dispute-resolution option.

Staff summarized the positions of the two parties on the reimbursement issue as follows: Carriers believe that requiring an insurer to pay more to an out-of-network provider than the insurer is required to pay under the federal Affordable Care Act (ACA) will undermine their provider networks and, by increasing payments to providers, will result in increases in health insurance premiums. Providers believe that the current requirement for payment to out-of-network providers in emergency situations, which is set out in § 38.2-3445 of the Code of Virginia and tracks the requirements of the ACA, is intended to set a floor on the total amount of compensation that the provider should be able to recover. In support of this position, they note that the ACA does not prohibit balance billing by such providers.

Staff pointed out several other points of disagreement in the emergency care scenario. One is the amendment to the definition of "emergency medical condition" proposed by the providers. Another is whether the obligation to hold the patient harmless is contingent upon the carrier's making direct payment to the provider. However, it was suggested that these points of disagreement may not be as intractable as the issue of the required reimbursement amount.

Staff's presentation closed with an overview of the Protecting Patients from Surprise Medical Bills Act, a discussion draft of which was introduced by Sen. Bill Cassidy(R-La.) on September 18, 2018. State laws do not apply to the roughly half of privately insured Americans enrolled in so-called self-insured health plans that are common among large employers, because the Employee Retirement Income Security Act (ERISA) precludes states from regulating these plans. The federal law would apply to ERISA plans as well as state-regulated health benefit plans. With regard to emergency services provided by an out-of-network provider, the draft bill would ensure that a patient is only required to pay the cost-sharing amount required by the patient's health plan, and a provider may not bill the patient for an additional payment. The excess amount above the cost-sharing amount will be paid by the patient's health plan in accordance with an applicable state law or an amount based on the greater of (i) the median in-network amount negotiated by health plans and health insurance issuers or (ii) 125 percent of the average allowed amount for the service provided by a provider in the same or similar specialty and provided in the same geographical area. The draft bill also addresses situations in which a patient receives non-emergency services following an emergency service from an out-of-network facility and in which non-emergency services are performed by an out-of-network provider at an in-network facility.

Surprise Balance Billing: Perspective of Virginia's Provider Community

Scott Johnson, speaking on behalf of the Virginia Medical Society, Virginia Hospital and Healthcare Association (VHHA), and several specialty provider organizations collectively referring to themselves as Virginia's Provider Community, summarized the group's proposed legislation dealing with emergency care. Under the proposal, clause (ii) of subdivision 4 of

Virginia Code § 38.2-3445 (which provides that one of the three amounts on which reimbursement for emergency services may be calculated is the amount the health carrier generally uses to determine payments for out-of-network services, such as the usual, customary, and reasonable amount) is replaced with an amount equal to 125 percent of the regional average for commercial payments for emergency services in 2018, as adjusted for inflation. The proposal also provides that out-of-network providers would:

- Give up the ability to balance bill their patients;
- Receive protections that the carrier would send payments directly to the provider and not to the patient;
- Be assured that a carrier will not be able to determine, on the basis of a final diagnosis, that an emergency medical condition did not exist; and
- Have the right, after good faith efforts to reach a resolution with the carrier, to request the BOI to determine if the proposed reimbursement complies with applicable requirements.

Mr. Johnson stated that amending the formula for determining the amount to be paid to an out-of-network provider on the basis of the regional commercial average gives protection that the amount being paid is fair. He added that he is committed to continuing to work on resolutions to the other scenarios involving non-emergency services.

In response to a question from Senator McDougle regarding whether insured patients should be billed for more than their copayment or other cost-sharing obligation when they receive medical services in an emergency situation, Mr. Johnson asserted that removing the ability to bill the patients would take away the negotiating power of physicians, which in turn would force physicians who were not willing to work for the payments offered to move out of town.

Surprise Balance Billing: Perspective of the Virginia Association of Health Plans

Doug Gray, Executive Director of the Virginia Association of Health Plans (VAHP), agreed that the participants have made progress in developing a solution that addresses non-emergency situations and confirmed that most of the tension involves emergency situations. He provided the HIRC with a proposal to ban surprise balance billing in emergency situations. Under the proposal, § 38.2-3445 would be amended to state that an individual shall not be required to pay the amount the out-of-network provider charges in excess of the amount the carrier is required to pay except applicable deductibles, copayment, coinsurance, or amounts deemed by the health carrier to be the patient's responsibility.

According to Mr. Gray, any solution should protect members from higher health care costs, protect networks, and encourage an appropriate site of care. He stressed that in most cases where a patient receives emergency services at an in-network hospital, the treating doctors are in the same network either as a result of being employed by the hospital or if they contract independently to provide services at the hospital as a result of contracting directly with the carrier to participate in its provider network. He also pointed out that a patient with a high deductible health plan is liable for the full amount of the cost of services until the amount of the deductible is met.

Mr. Gray criticized the providers' proposed requirements on the basis that they that would increase the amount of payments to out-of-network providers and ban balance billing only where the carrier makes direct payment to the carrier but not when payment is sent to the patient. In his view, these provisions by guaranteeing reimbursement payments to providers at higher levels

would create incentives for providers to stay out of carrier networks. Increasing the amount of payments to out-of-network providers will lead to higher health insurance premiums and smaller networks, both of which will hurt consumers.

With respect to non-emergency situations where an in-network facility seeks to provide an enrollee with an out-of-network provider without the patient's knowledge or approval, Mr. Gray agreed that the patient should not be balance billed.

Senator Wagner remarked that health care is the only area where the consumer has no idea what the cost will be of a procedure and that the charges listed by a provider bear no relationship to amount actually billed. The lack of competition is resulting in price increases. He asked whether a solution to the problem of hospitals acting as unregulated monopolies would be to have them regulated by the State Corporation Commission.

Surprise Balance Billing: Other Perspectives

Sara Cariano of the Virginia Poverty Law Center noted that the group's discussions have not addressed all of the points raised by Jill Hanken at the HIRC's preceding meeting. Specifically, she urged the group to eliminate balance billing by out-of-network providers in emergency situations without regard to whether the hospital at which the services were provided is in the patient's carrier's network. She also urged members to focus on ensuring that carriers have adequate networks, because the chances of being balance billed would be greatly reduced if carriers were required, as a condition for approval of their managed care plans, to ensure that patients who receive emergency services in an in-network hospital receive those services from in-network providers.

Brent Rawlings of the VHHA concurred with the remarks by Mr. Johnson. He countered Senator McDougle's suggestion that a hospital should bear the cost of balance billing when its patient receives emergency services from an out-of-network physician by noting that the hospital has no say in determining whether a physician with whom it has contracted is going to agree to contract with an insurance carrier. In such a case, the physician is responsible for negotiating contracts with insurers. In Mr. Rawlings' view, the proposal submitted by the VAHP does not provide a balanced solution. Responding to a query by the Chair, Mr. Rawlings reminded the members that balance billing of patients covered by Medicare or Medicaid is prohibited by federal law.

House Bill 1433/Senate Bill 860: Vertically Integrated Carriers and Public Hospitals

During the 2018 Session of the General Assembly, Senator Louise Lucas introduced Senate Bill 860, and Delegate Jay Leftwich introduced House Bill 1433. These identical bills would have required any vertically integrated carrier, which is a health insurer or other carrier that owns an interest in an acute care hospital facility, to offer to every public hospital the ability to participate in the provider panels or networks established for each of the carrier's policies, products, and plans. As introduced, the measure also requires any contract by which a public hospital participates in a vertically integrated carrier's provider panel or network to obligate the carrier to reimburse the public hospital for a covered health care service at a rate that is not less than the fair and nondiscriminatory rate. The amendment in the nature of a substitute for Senate Bill 860 removed the provisions regarding fair and nondiscriminatory rates.

House Bill 1433 was tabled in the House Commerce and Labor Committee. Senate Bill 860 passed the Senate by a vote of 21-18-1 and was referred to the House Commerce and Labor

Committee, where it was tabled with agreement that the Chairman would request the HIRC to examine the issues raised by the legislation during the interim.

Reese Jackson, chief executive officer of Chesapeake Regional Medical Center (CRMC), relayed to the HIRC the rationale for his support of the legislation: By excluding CRMC from the network of hospitals within the network of the Optima Health managed care plan, Sentara Healthcare is creating a clear and present danger to public interests. Sentara Healthcare dominates the market share for adult acute care hospitals in the Hampton Roads region. As a result, South Hampton Roads is not reflective of a free market.

Mr. Jackson believes that the legislation balances public and private interests in a public-private contract and is aimed at the inherent conflict of interest of a hospital-owned health plan. In his view, low-cost facilities, such as CRMC, should not be excluded in order to boost the profits of Sentara, which has broken the normal economic system through its ownership of an insurance product. Through Optima Health, its health plan subsidiary, Sentara can "tier and steer" and limit competition. Tiering refers to separating hospitals into different groups on the basis of the cost and the quality of care they provide, and steering refers to creating incentives for patients to obtain services at hospitals that are under common ownership with the insurer. He asserted that Sentara's conflict of interest to restrict services is a clear and present danger to public interests.

Michael Gentry, senior vice-president and chief operating officer of Sentara Healthcare, responded that Sentara's decision to establish Optima Health resulted from the desire to create an integrated system and that the health care of consumers is improved by coordination between care and cost containment. He argued that a vertically integrated system is better positioned to improve the health outcomes of its membership. He noted that Sentara allows outside entities to participate in its network. With regard to CRMC's assertions, he cited several examples of projects in which Sentara offered to partner with CRMC but the offers were not accepted. He agreed that concerns with the costs of health care and rising insurance premiums are valid, but the approach reflected in House Bill 1433 and Senate Bill 860, which would force an entity to accept another entity into its network, does not have a track record of working.

Senator McDougle asked whether requiring a vertically integrated carrier to include public hospitals in its network was justified as a means of forgoing the regulation of a monopoly. In response. Mr. Gentry noted that for over 30 years CRMC participated in Optima's network, and the fact that it no longer participates does not mean that government should be involved in the market.

Senator Wagner noted that he saw an inherent conflict of interest when a hospital and insurer are owned by the same entity. When asked what would be his response if a law prohibited the entity from doing both types of business, Mr. Gentry questioned why the General Assembly would do so. He noted that Sentara Healthcare has been named a Top 15 Health System for 2018 by IBM Watson Health, which recognizes that the system has being exceptionally well run, as demonstrated by outcomes in mortality, complications, health care-associated infections, and other criteria.

Senator McDougle acknowledged the existence of philosophical differences and observed that Virginia has set up the State Corporation Commission with the ability to regulate rates. Mr. Gentry closed by noting that Optima Health has eight percent of the insurance market in the Commonwealth. His firm is looking for more competition, but characterized the proposed legislation as protectionism, while he is seeking affordable health care for the community.

Mr. Jackson stated that the legislation excludes Anthem, Kaiser, and VCU Health Systems, though this was contradicted by Melissa Hancock of VCU Health Systems. Ms. Hancock objected to the legislation on grounds that it would limit VCU's discretion in determining the providers with which its Virginia Premier insurer would enter into contracts. She countered suggestions that vertically integrated carriers favored their subsidiaries by noting that Virginia Premier uses a firewall to insulate contract negotiations with inside providers from those with outside providers. In response to Senator Wagner's suggestion that it is a system that needs to be subject to price regulation, Ms. Hancock said that VCU Health Systems views Virginia Premier as a way to reduce costs to consumers and create full value for citizens of the Commonwealth. Senator McDougle asserted that where there is no competition that provides consumers with choices, he would want to look at the issue of regulating the market.

House Bill 1001/Senate Bill 639: Health Care Shared Savings Incentive Programs

House Bill 1001 and Senate Bill 639 were introduced in the 2018 Session of the General Assembly by the HIRC Chair Kathy Byron and Senator Siobhan Dunnavant, respectively. As introduced, the bills would have required health carriers to establish a comparable health care service incentive program under which savings are shared with a covered person who elects to receive a covered health care service from a lower-cost provider. The bills would have required health carriers to make available an interactive mechanism on their website that enables a covered person to compare costs between providers in-network, calculate estimated out-of-pocket costs, and obtain quality data for those providers, to the extent available. The bills would have authorized covered persons to obtain health care services from out-of-network providers if their costs are below the average of in-network providers. They also would have required health care facilities and practitioners to provide a covered person with an estimate of charges prior to an admission, procedure, or service. Amendments in the nature of a substitute for House Bill 1001 and Senate Bill 639 reduced the minimum amount of the health carrier's saved costs resulting from comparison shopping that the incentive program is required to provide to covered persons from 50 percent to 25 percent. The substitutes also removed the provisions that would have (i) required providers and facilities to provide prospective patients with cost estimates and to post notices and (ii) allowed covered persons receiving a covered health care service from an out-of-network provider to apply the payments made toward his deductible and out-of-pocket maximum as if the health care services had been provided by a network provider. The substitute for House Bill 1001 failed to advance on a tie vote on the floor of the House of Delegates, and the substitute for Senate Bill 639 was continued to the 2019 Session in the Senate Finance Committee.

Josh Archambault, senior fellow at the Opportunity Solutions Project, presented the HIRC with the case for supporting shared savings, or "right to shop," legislation. Pursuant to provisions of the 2017 Budget Bill, the Department of Human Resource Management commenced a shared savings program for the state employee health benefits program in October 2018, and Mr. Archambault urged the HIRC to support expanding the program to apply to private insurance plans. In his view, such programs are of particular benefit to persons insured under high deductible plans. The lack of transparency in the cost of medical services, he reported, is a driving force in the explosion of health care costs.

The three pillars of "right to shop" legislation are individualized transparency, incentives to shop, and patient freedom and choice. As outlined by Mr. Archambault, patients receiving services from in-network providers would receive a payment from their insurer equal to a percentage of

the savings realized by the insurer as a result of the patient's obtaining the services from the lowest-cost provider. Under the program, a patient who finds lower-cost care out of his plan's network would not receive an incentive payment but would receive credit toward his deductible. New Hampshire and Kentucky were identified as two other states that have implemented shared savings incentive programs for public employees. Similar laws have been enacted in Maine and Arizona.

Rate Filings for 2019

David Shea, the BOI's health actuary, provided the HIRC with a report on the BOI's rate review conducted for qualified health plans to be offered for 2019. After reviewing the process used by the BOI in conducting its rate reviews, Mr. Shea focused on new provisions implemented through the BOI's 2019 guidance to carriers. The guidance document requires carriers to use induced demand factors developed by the federal Centers for Medicare and Medicaid Services. The reliance on the federally developed factors created a more level playing field than in prior years and made the rate review process more efficient. Another new provision for 2019 filings is the use of a standardized filing template that addresses carrier experience data, projections, and other factors. The uniform filing template has made it easier for the BOI to analyze statewide markets and identify outliers in premium rate drivers.

Mr. Shea reported that the final approved average rate changes for policies in the individual market, both on and off the Health Insurance Marketplace, are in most cases substantially less than the rate changes initially proposed by carriers. He noted that the cumulative savings between proposed average rates and final approved average rates in the individual market will be $81.6 million. Mr. Shea was not able to provide data requested by the Chair regarding the premiums for coverage in 2019 for specific types of purchasers, as his data reflected the average premiums for plans for all ages and geographic areas. He undertook to provide samples of premiums for different categories of consumers and plans at the HIRC's next meeting.

Short Term Limited Duration Plans

Julie S. Blauvelt, deputy commissioner of the BOI's Life and Health Division, briefed the members of the HIRC on new federal rules regarding short term limited duration (STLD) health insurance policies. She noted that STLD policies are exempt from the federal market requirements applicable to individual and group health insurance coverage. As a result, they are not subject to requirements applicable to qualified health plans, including provisions addressing essential health benefits, preexisting conditions, and lifetime or annual dollar limits.

Pursuant to federal rules adopted in 2016, the maximum term of STLD plans was capped at three months. New federal rules effective October 2, 2018, define STLD coverage as coverage that has a term that is less than 12 months and a duration of no longer than 36 months in total. The new federal rules are intended to address the rising financial burden for the unsubsidized population attributed to increasing premiums for ACA coverage, the declining enrollment of persons purchasing coverage on exchanges without federal subsidies, and the limited choices of ACA coverage as carriers leave the market.

Ms. Blauvelt pointed out several key differences between ACA-compliant major medical health plans and STLD plans. For example, STLD policies issued in-state with an initial term that exceeds six months or that is underwritten must be renewable up to 36 months, while policies issued in-state with a term of no more than six months and that is not underwritten may be either

nonrenewable or renewable up to 36 months. While STLD policies are not required to provide coverage for the essential health benefits, policies issued in-state are required to provide only mandated benefits while policies issued to Virginians through an out-of-state association are not subject to a minimum benefit requirement.

The new federal rules require the prominent display of a notice in a contract and application materials for a STLD policy that addresses how coverage under the policy might vary from individual health insurance coverage. Under the new federal rules, states are allowed to impose a shorter maximum initial contract term and a shorter maximum duration to meet specific market needs, including the need to mitigate adverse selection in the individual market. Except as to rules on notice and duration, the federal rules do not limit the extent to which a state may regulate coverage under STLD plans. Moreover, the new federal rules do not preempt any state laws prohibiting the sale of STLD insurance.

Copies of meeting materials may be found at the HIRC's website: http://dls.virginia.gov/commissions/hir.htm?x=mtg

Kathy J. Byron, Chair

Division of Legislative Services contact: Frank Munyan