Meeting Summary

Health Insurance Reform Commission

September 17, 2019, at 12:30 p.m.

The Pocahontas Building, House Committee Room

dls.virginia.gov/commissions/hir.htm

The Health Insurance Reform Commission (the HIRC) met in Richmond with Delegate Kathy J. Byron, chair, presiding. A quorum of nine members was present.[1]

The duties of the HIRC include monitoring the work of federal and state agencies in implementing the provisions of the federal Patient Protection and Affordable Care Act (ACA); assessing the implications of the ACA's implementation on residents, businesses, and the general fund of the Commonwealth; considering the development of a comprehensive strategy for implementing health reform in Virginia; recommending health benefits required to be included within the scope of the essential health benefits provided under health insurance products offered in the Commonwealth; assessing proposed mandated benefits and providers; conducting other studies of mandated benefits and provider issues as requested by the General Assembly; and developing recommendations to increase access to health insurance coverage, ensure that the costs to business and individual purchasers of health insurance coverage are reasonable, and encourage a robust market for health insurance products in the Commonwealth.

Copies of materials presented at the meeting are accessible on the *Commission's meeting webpage*.

Charity Care Collection Efforts

Eric Bodin, Director, Division of Certificate of Public Need, Virginia Department of Health

Pursuant to the second enactment of House Bill 2101 of the 2017 Session, the Commissioner of Health is required to prepare an analysis of charity care that each medical care facility provided to indigent persons. The report is required to compare the value of the total amount of charity care that each medical care facility provided to indigent persons with the medical care facility's cost and to include an assessment of the portion of the total amount of charity care provided that each service represents to comply with any conditions on certificates of public need (COPNs). Mr. Bodin made a report to the HIRC on the implementation of House Bill 2101in May 2018. At this meeting, he provided an update on the charity care data collection efforts.

Mr. Bodin's presentation focused on the shift in the method by which the value of charity care is measured. Previously, charity care had been valued at the provider's chargemaster. Under the new methodology, the value of charity care provided is required to be reported on the basis of Medicaid reimbursement rates.

The Virginia Health Information (VHI) is collecting the annual charity care reports under the new requirements. Facilities are required to file charity care reports with VHI within 90 days

[1] **Members Present:** Delegate Kathy J. Byron (chair), Delegate R. Lee Ware, Delegate David E. Yancey, Delegate Eileen Filler-Corn, Senator Rosalyn Dance, Senator Ryan T. McDougle, Senator Richard L. Saslaw, Senator William M. Stanley, Jr., and Commissioner of Insurance Scott White

Member Absent: Secretary of Health and Human Resources Daniel Carey

from the end of the facility's fiscal year. VHI is actively collecting reports from the facilities that have certificates of public need issued on the condition of the provision of charity care for fiscal years that ended in calendar year 2018, while the requirement for collection from facilities that do not have conditioned certificates of public need became effective on July 1,2019. To date, 96 percent of hospitals and about 40 percent of outpatient providers have completed their reports.

Conditions for the provision of indigent care on COPNs are now written to reflect the new valuation of charity care based on Medicare reimbursement rates. With respect to certificates issued prior to effective date of the new requirements, certificate holders may request changes to the rate. Virginia Code § 32.1-102.4 requires a review of conditions every three years. However, new conditions may be applied subject to consent of the applicant or certificate holder.

Balance Billing Issues: Proposed Regulations; Status of Balance Billing Work Group

Julie S. Blauvelt, Deputy Commissioner, Life & Health Division, Bureau of Insurance (BOI)

Ms. Blauvelt reported that on June 9, 2019 the State Corporation Commission (SCC) issued proposed rules governing balance billing for elective health care services. The requirements of the proposed regulations are intended to supplement, and not replace, the requirements of Virginia Code § 38.2-3445.1, which were enacted in the 2019 Session of the General Assembly pursuant to House Bill 2538.

The proposed rules are intended to address the aspect of surprise balance billing that occurs when elective services are received from a non-participating provider at an inpatient or outpatient in-network facility without the patient's knowledge that a non-participating provider will be providing services at the in-network facility. In these situations, the health plan makes some payment for the service provided by the non-participating provider, but the patient is billed for the balance of the non-participating provider's charges, in addition to the patient's required deductible, co-payment, or other cost sharing obligation.

The proposed rules attempt to help increase the potential that consumers are made aware of a possible surprise balance billing situation by enhancing the notice to be provided to the patient in the situation the General Assembly addressed in House Bill 2538. The proposed rules would require provider agreements between a health carrier and facility to include provisions that obligate the participating facility to:

1. Notify a patient at pre-admission or pre-registration for elective services if they will or are likely to obtain services from an out-of-network provider;
2. Document the notification in writing;
3. Obtain the patient's prior written consent to either accept services from in-network providers only or accept services from out-of-network providers; and
4. Indicate in this notice that elective health care services received from an out-of-network provider may result in amounts owed in addition to any cost-sharing requirements.

The proposed rules also provide that a participating facility that fails to comply with these requirements will be financially responsible for surprise balance billing amounts for elective services rendered by the out-of-network provider.

The proposed rules currently are under consideration by the SCC. The SCC conducted a hearing on the proposed rules on September 12, 2019, and has received comments addressing legal issues.

Ms. Blauvelt also updated the HIRC on the work of the balance billing workgroup established pursuant to Item 281 F of the 2019 Appropriations Act. The item directs the Secretary of Health and Human Resources, in collaboration with the Secretary of Administration, Secretary of Finance, and SCC, to convene a workgroup to evaluate options to prohibit the practice of balance billing by out-of-network health care providers for emergency services rendered, and to establish equitable and fair reimbursement for these health care providers. The workgroup is directed to report on the fiscal impact of each option considered and the impact on provider networks and to include recommendations for future legislation. Its report is due by November 15, 2019.

The workgroup met on August 28, 2019. Issues addressed included surprise balance billing in Virginia, other state and federal activity on surprise billing, and nine related bills that were introduced in the 2019 Session General Assembly.

At its next meeting on September 18, 2019, the workgroup is scheduled to work with 2019 proposals and to develop three options that will then be assessed as to their fiscal impact and impact on provider networks.

Federal Developments Relating to Balance Billing

Jeanette Thornton, Senior Vice President, America's Health Insurance Plans (AHIP)

Ms. Thornton reported that the prospects for the enactment of federal legislation addressing surprise balance billing are uncertain. She noted that popular support exists for such legislation, in part due to the fact that surprise balance billing affects at least one in five Americans annually. Per Ms. Thornton, surprise balance billing is a concentrated problem among certain medical specialties and in states where freestanding emergency departments and provider consolidation have become common.

Ms. Thornton reported that at least 21 states have acted to reduce surprise balance billing, with varying success. She noted that state laws do not apply to the more than 100 million Americans who have health coverage through their employer's self-funded plans, which are not subject to state oversight pursuant to the federal Employee Retirement Income Security Act of 1974 (ERISA). Another issue that states are currently preempted from addressing is air ambulance services.

AHIP advocates a solution that bans balance billing in situations where patients are involuntarily treated by an out-of-network provider in emergency situations, when services are provided by an out-of-network doctor at in-network facility, and for ambulance transportation. A solution should also provide that patients are held harmless for liability in such situations.

Ms. Thornton recommended that health carriers be required to reimburse non-participating providers based on local market rates negotiated by other doctors in the area. This solution, she suggested, would not raise health care costs and would maintain robust health insurance networks. She was critical of proposed solutions that would establish an arbitration process that increases costs for patients, businesses, and taxpayers. She was particularly critical of private equity firms that have established emergency room physician practices that contract to provide staffing at hospitals without participating in the hospital's health insurance networks. These firms

have aired advertisements aimed at stopping a federal solution to balance billing, which, per Ms. Thornton, have been found to be false.

In response to a question by Delegate Ware regarding what she expects to happen, Ms. Thornton noted that the situation is changing by the hour. While different bills have passed committees of the House of Representatives and U.S. Senate, neither house has had a floor vote. She noted that it is possible that such legislation could be part of a year-end legislative package.

Rates and Policies on the Exchange for 2020

Toni Janoski, Policy Advisor, Policy, Compliance & Administration Division, BOI

The BOI reported that final rates for health plans in the individual and small group markets to be offered in 2020 have been finalized. For 2020, the average per member per month rate for individual policies sold on and off the Exchange will be $743.58. While this represents a decrease of approximately $53 per month from the 2019 average of $796.29, the 2020 average rate will be the second-highest since Virginia began participating in the Exchange in 2014.

The BOI projects that individual on and off exchange total enrollment for 2020 will be 303,225, which is an increase of about 3,000 over the corresponding figure for 2019, but nearly 115,000 fewer than the peak reached in 2016.

Ms. Janoski reported that the number of carriers operating in the individual market in 2020 has increased, with two new carriers entering the market. Two or more carriers will be operating in 58 percent of Virginia localities in 2020.

Data on the status of the small group market was also presented. Average rates for 2020 have increased by 2.1 percent compared to 2019 rates, to $539.83. The change was attributed to favorable claims experience, the medical cost trend holding steady, and the movement of the "super small" groups into the small group market, which is putting upward pressure on rates due to projections of a higher morbidity rate in this population. The number of participants in the small group market is greater than in the individual market, as illustrated by the fact that each of Virginia's localities will have at least 10 carriers. The number of persons obtaining coverage through the small group market is more stable than the individual market, with the number for 2020 projected to be 363,516.

Senator McDougle observed that when the number of insured persons in the individual and small group markets is aggregated, the data shows a drop from over 811,000 in 2015 to a projected number of over 666,000 in 2020. The drop was attributed to several factors, including increased premiums in the individual market, persons switching to Medicaid or large group coverage, and persons aging into Medicare eligibility.

Mandated Benefits in Virginia: Their History and Costs

Donald Beatty, Deputy Commissioner, Policy, Compliance & Administration, BOI

Mr. Beatty identified three historical sources of health benefit mandates. ERISA imposes certain requirements on self-funded and fully-insured employer health plans. State governments have required carriers to provide certain benefits in fully-insured employer plans and in individual health plans. The federal ACA requires fully-insured small employer group plans and individual health plans, and to some extent self-funded and fully-insured employer health plans, to provide 10 categories of essential health benefits (EHBs).

Rather than specify what specific benefits fall into the 10 EHBs, the federal government allows states to identify a benchmark plan being offered in the state that covers the 10 categories, with the specifically required benefits being those provided under that benchmark plan. Virginia chose the most popular plan offered in the small group market as its benchmark plan. By incorporating the benefits provided under an existing state-approved plan, all state-mandated benefits are included in the EHBs. Virginia's benchmark plan includes benefits that were not previously required by ERISA or state mandates. For example, while maternity and prescription drugs had not been required to be provided in plans sold in the individual market, they are ACA-required EHBs that are now covered.

Comparing the number of state-mandated health insurance benefits may be problematic because a state may require coverage of a benefit thorough a mechanism other than enacting legislation. Nevertheless, one study noted that in 2009, Virginia, with 34 mandates, ranked seventh among states in number of mandates. The study found that Rhode Island had the most mandates (44) and Idaho had the fewest (6). The average number of mandates across all states was 40.

Mr. Beatty noted that Virginia may be an outlier in terms of the benefits mandated by state law. Only two other states mandate hemophilia treatment. Virginia is the only state mandating a minimum hospital stay for a hysterectomy. Only four other states mandate coverage for treatment of lymphedema.

Given that all states are required to ensure that health plans cover all ten EHB categories, states are fairly aligned as to what is required of plans sold in the individual and small group markets related to EHBs.

With regard to the cost of Virginia's existing mandated health insurance benefits, Mr. Beatty reported that the average annual claim cost per contract was $747 for individual contracts and almost $1,238 for group contracts.

Federal law establishes a procedure by which a state may revise its EHB benchmark. To do so, a state is required to request a waiver under § 1332 of the ACA, with request due by the July 1 that is 18 months prior to the calendar year in which the revision to the EHB benchmark would be effective. A proposed new EHB benchmark is required to (i) be an EHB benchmark used by another state, (ii) replace a category of EHBs from the state's existing benchmark with a category used by another state's benchmark; or (iii) choose its own set of EHBs within parameters that include providing a scope of benefits at least as great as a typical employer plan.

Mr. Beatty closed by noting that if the HIRC is considering making changes to the state-mandated benefits or EHB benchmark plan, a study should be done to pinpoint and evaluate proposed changes. Commissioner White commented that the BOI would need to be requested to conduct an analysis of the effects of a proposed change in the EHB benchmark before doing so. In response to an inquiry by the chair as to how such a request would be made, staff suggested that it may be by legislation or by executive order, among other means. The BOI noted that the Governor's office has traditionally been the entity that has selected the EHB benchmark.

The chair also asked whether the "mandate light" policies could still be offered to employers in the small group market. Ms. Blauvelt noted that such plans would still be permitted only if they qualified as "grandfathered" plans under the ACA. Grandfathered plans are health plans that are existing without major changes to their provisions since the date of the ACA's enactment.

Work Plan for Step Two Assessments

Van Tompkins, Policy Advisor, Policy, Compliance & Administration, BOI

At the HIRC's meeting on May 6, 2019, the HIRC received Step One assessments of the nine bills referred to the HIRC that sought to establish new mandated health benefits. Following a discussion of whether to direct the BOI and the Joint Audit and Review Commission (JLARC) to conduct Step Two assessments of these bills, the BOI undertook to prepare a work plan for an approach to the conduct of Step Two assessments. At this meeting, Ms. Tompkins briefed the members on the procedure by which the BOI and JLARC would conduct Step Two assessments when directed by the HIRC. She estimated that conducting a Step Two assessment of a bill would take approximately 12 weeks. It was reported that JLARC and the BOI are limited in the number of Step Two assessments that they can undertake at a given time based on other projects affecting agency workload. She noted that HIRC has 24 months in which to complete its assessment of legislation. Both agencies estimated that they could complete no more than one or two Step Two assessments by December 2019.

Senator McDougle moved that the HIRC request the BOI and JLARC to conduct a Step Two assessment of House Bill 2177 from the 2019 Session and submit its report prior to the 2020 General Assembly Session. The bill, introduced by Delegate Murphy, would require health carriers to cover medically necessary formula and enteral nutrition products on the same terms and subject to the same conditions imposed on other covered medicines. The HIRC agreed to this motion by voice vote.

Recommended Health Insurance Reforms

James C. Sherlock, Captain, U.S. Navy (Ret.)

Captain Sherlock presented the HIRC with his recommendations to reform the health insurance system. Four of the recommendations address the system for issuance of certificates of public need (COPN). First, he recommended exempting physician-owned surgical centers (POSCs) from the COPN process as has been done in Maryland. Second, he suggested Virginia follow Maryland in exempting rural hospitals from COPN requirements when converting existing inpatient facilities to ambulatory and emergency facilities. Third, follow Maryland's lead and establish health enterprise zones (HEZs) in the state's poorest regions. In these HEZs, ambulatory surgical centers, imagery centers, and equipment purchases for healthcare delivery facilities would be exempt from COPN requirements.

Captain Sherlock's fourth COPN recommendation, for which Maryland has not established a precedent, is to move COPN administration from the Department of Health (VDH) to the SCC. This move would, it was argued, unite oversight of health insurance and the business of healthcare. In addition, he suggested that the SCC is more capable of overseeing the business of healthcare than VDH. Captain Sherlock also recommended banning provider systems from ownership or control of HMOs and health insurers. He also cited the woeful financial condition of many rural hospitals and asserted that the general hospital business model is unsustainable in rural locations.

Other Business; Public Comment

Delegate Yancey asked Ms. Blauvelt if the BOI has quantified the costs of establishing a reinsurance program for health carriers. She replied that the BOI had used federal grant funds to

retain an actuary to conduct such a study based on 2019 rates and pledged to provide a copy of the data. She added that the BOI could update the data under the grant in 2021.

One person asked to provide comment at the close of the meeting. Ian Dixon, representing a group based in Charlottesville advocating for reasonable health insurance costs, expressed concern over Optima's premiums in 2018. Mr. Dixon asserted that these rates were the highest rates in the country and resulted in a medical cost ratio (MCR) of less than 50 percent. As a result of such a low MCR, the BOI is requiring it to pay refunds to its policyholders. He stated that the BOI has also issued a finding of noncompliance related to overcharges by Optima. Mr. Dixon urged the conduct of formal hearings into Optima's practices and noted that *The Wall Street Journal* has recently published an article on this topic. He also asked that he be permitted to present details on this topic at the next HIRC meeting.

Next Meeting

The HIRC intends to hold its next meeting prior to the 2020 Session, at a time and place to be determined, at which time it will receive the Step Two analysis of House Bill 2177.

For more information, see the *Commission's website* or contact the Division of Legislative Services staff:

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