HEALTH INSURANCE REFORM COMMISSION

EXECUTIVE SUMMARY OF 2018 INTERIM ACTIVITY AND WORK

February 2019

I. BACKGROUND

Chapter 53 (§ 30-339 et seq.) of Title 30 of the Code of Virginia charges the Health Insurance Reform Commission (HIRC) with:

- Monitoring the work of appropriate federal and state agencies in implementing the provisions of the federal Patient Protection and Affordable Care Act (the ACA), including amendments thereto and regulations promulgated thereunder;
- Assessing the implications of the ACA's implementation on residents of the Commonwealth, businesses operating within the Commonwealth, 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 (EHBs) provided under health insurance products offered in the Commonwealth, including any benefits that are not required to be provided by the terms of the ACA;
- Assessing proposed mandated benefits and providers and recommending whether, on the basis of such assessments, mandated benefits and providers be providers under health care plans offered through a health benefit exchange, outside a health benefit exchange, neither, or both;
- Conducting other studies of mandated benefits and provider issues as requested by the General Assembly; and
- Developing such recommendations as may be appropriate for legislative and administrative consideration in order 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.

The HIRC is chaired by Delegate Kathy Byron (the Chair). Senator Frank Wagner serves as the HIRC's vice-chairman. The other members of the HIRC are Delegates Lee Ware, David Yancey, and Eileen Filler-Corn and Senators Rosalyn Dance, Richard Saslaw, and Ryan McDougle. Commissioner of Insurance Scott White and Commissioner of Health and Human Resources Daniel Carey serve as ex officio nonvoting members.

The HIRC met three times during the 2018 interim, on May 24, 2018, July 16, 2018, and October 16, 2018.

This executive summary of the interim activity and work of the HIRC is submitted pursuant to § 30-345 of the Code of Virginia.

II. ISSUES ADDRESSED

A. Legislation Referred for Study

Seven bills were referred to the HIRC during the 2018 Session of the General Assembly. The HIRC took the following actions with respect to these bills:

1. House Bill 131, which was introduced by Delegate John Bell and relates to coverage for alternative pain management drugs.

Of the seven bills referred to the HIRC, House Bill 131 and House Bill 434 were the only two measures that would mandate carriers to provide coverage for a health insurance benefit. At the HIRC's May 24, 2018, meeting, Van Tompkins, Policy Advisor at the Bureau of Insurance (BOI) of the State Corporation Commission, presented the BOI's Step I assessments of the two bills. A Step I assessment is an analysis, conducted pursuant to subsection B of § 30-343, of the extent to which a proposed mandated health insurance benefit is currently available under qualified health plans (QHPs) in the Commonwealth and a report on whether the mandated benefit exceeds the scope of the essential health benefits (EHBs) that are required by the ACA to be covered under QHPs. The latter issue is relevant because the ACA requires states to pay the cost of covering certain mandated benefits under health plans sold on the Exchange.

Ms. Tompkins presented the BOI's Step I assessment of House Bill 131, which noted that carriers currently cover primarily non-opioid analgesic medications. She noted that guidance from the Centers for Medicare and Medicaid Services (CMS) suggests that the requirements of House Bill 131 would not be considered under federal rules to be in addition to essential health benefits. Per the CMS guidance, the ACA's prescription drug EHB policy sets minimum requirements and health benefit plans are permitted to go beyond the number of drugs offered by the benchmark plan. CMS has concluded that requiring plans to cover more drugs than are covered under the state's benchmark plan does not require coverage that exceeds the EHBs. Based on this information, the HIRC did not request the BOI to conduct a Step II assessment for House Bill 131.

2. House Bill 386, which was introduced by Delegate Glenn Davis and relates to step therapy protocols.

After consultation with the BOI, it has been determined that the bill would not be considered a mandate for the purposes of the ACA. Therefore, the HIRC is not required to follow the two-step analysis process for reviewing mandates that is codified in § 30-343. The HIRC noted that it had studied Senate Bill 1408 related to step therapy protocols during the 2017 interim. Per subsection D of § 30-343, the HIRC is not required to conduct an assessment of bills that are substantially similar to measures reviewed in the preceding three years.

3. House Bill 434, which was introduced by Delegate David Yancey and pertains to coverage for proton therapy.

The BOI prepared a Step I assessment of this bill in which it concluded that QHPs are currently required to provide coverage for radiation therapy in the Virginia Essential Health Benefit Benchmark Plan. The BOI would therefore characterize proton therapy as an extension or clarification of an existing EHB rather than a new or additional EHB. As part of the Step I assessment, Ms. Tompkins noted that the BOI understands that hypofractionated proton therapy (HPT) is more expensive than standard intensity modulated radiation therapy (IMRT) and that carriers have looked to independent studies to determine if the cost of the more expensive therapy is warranted for the treatment of certain cancers. Carriers currently cover HPT as an alternative to IMRT for ocular tumors, pediatric cancer, and certain types of brain cancer because independent studies reflect the benefit of HPT over IMRT for these particular cancers. She noted that House Bill 434 would expand upon the use of HPT treatment for other cancers and would have carriers pay for the investigation into its expanded use.

Doug Gray of the Virginia Association of Health Plans (VAHP) observed that § 38.2-3418.8 of the Code of Virginia requires carriers to cover patient costs incurred during clinical trials for treatment studies on cancer. The medical services under a legitimate clinical trial are provided to the patient at no cost. Accordingly, House Bill 434, by requiring insurance coverage for medical services that are currently provided without charge, distorts the existing clinical trial mandate. Senator McDougle questioned whether the measure is appropriate given its inconsistency with the existing mandate for coverage of clinical trial costs and the coverage currently provided for radiation therapy. The HIRC took no further action on House Bill 434.

4. House Bill 583, which was introduced by Delegate Robert Bloxom and pertains to a state-based reinsurance program.

After receiving an overview of the measure, Senator Wagner noted that the Appropriation Act (Chapter 2 of the Acts of Assembly, 2018 Special Session I) authorizes the Secretary of Health and Human Resources to develop and apply for a state innovation waiver under § 1332 of the ACA to implement innovative solutions to help stabilize the individual insurance market by reducing individual insurance premiums and out-of-pocket costs while preserving access to health insurance. The provision provided that such solutions may include the implementation of a state reinsurance program. As this was a topic expected to be addressed in the course of the Secretary's study of measures to stabilize the individual insurance market pursuant to Item 281 of the Appropriation Act, the HIRC took no further action on House Bill 583.

5. House Bill 1190, which was introduced by Delegate David Toscano and pertains to companies offering Medicaid managed care plans required to offer plans on the Exchange.

After consultation with the BOI, it has been determined that the bill would not be considered a mandate for the purposes of the ACA. Therefore, the HIRC is not required to follow the two-step analysis process for reviewing mandates that is codified in § 30-343. The HIRC took no further action on this bill.

6. House Bill 1584, which was introduced by the Chair and relates to balance billing for ancillary services.

Because this bill would not be considered a mandate for the purposes of the ACA, the HIRC is not required to follow the two-step analysis process codified in § 30-343. Though the HIRC took no formal action specifically on House Bill 1584, the issue of surprise balance billing was a major focus of the HIRC's meetings in July and October 2018, and is discussed in Part D of this Executive Summary.

7. Senate Bill 860, which was introduced by Senator Louise Lucas and pertains to a requirement that vertically integrated carriers allow public hospitals to participate in the provider panels or networks established for the carrier's plans.

As with four of the other bills referred to the HIRC, Senate Bill 860 would not be considered a mandate for the purposes of the ACA. Accordingly, the HIRC is not required to follow the two-step analysis process codified in § 30-343 with respect to this bill.

Though the HIRC did not take formal action on Senate Bill 860, it received additional information on the issues raised by this bill and its House counterpart (House Bill 1433 patroned by Delegate Jay Leftwich) at its meeting on October 16, 2018. 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. Mr. Gentry responded 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 statistics elated to 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. 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.

B. Other Health Insurance Legislation from the 2018 Session

At the May 24, 2018, meeting, Ms. Tompkins provided an overview of the following nine health insurance-related bills that were enacted during the 2018 legislative session:

1. House Bill 139 (Delegate Head), which requires health insurers and other carriers that credential the physicians in their provider networks to establish procedures for reimbursements after their credentialing application is approved.
2. House Bill 234 (Delegate Hope), which requires insurers to adopt mechanisms that allow an enrollee to synchronize medications.
3. House Bill 778 (Delegate Ransone) and Senate Bill 663 (Senator McPike), which require hospitals, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition, to provide the patient with notice that the patient (i) may have a choice of transportation by an air medical transportation provider or ground transportation and (ii) will be responsible for charges incurred for such transportation if the provider is not in the patient's health insurance network.
4. House Bill 1177 (Delegate Pillion) and Senate Bill 933 (Senator Saslaw), which among other things prohibit the charging of a copayment for a covered prescription drug that exceeds the cash price of the prescription drug.
5. House Bill 1368 (Delegate Jay Jones), which disqualifies a discharged employee from continuation of health insurance coverage under his former employer's group policy if the employee was discharged as a result of gross misconduct, unless such disqualification is prohibited pursuant to the federal Consolidated Omnibus Budget Reconciliation Act.
6. Senate Bill 717 (Senator Chase), which requires that premium rate filings for certain health benefit plans include a description of agent commissions and any limitations or exceptions as they relate to the payment of such commissions.
7. Senate Bill 672 (Senator Deeds), which revises the definition of "small employer" for purposes of health insurance to include a sole proprietor or an individual who is the sole shareholder of a corporation or sole member of a limited liability company who performed services for remuneration for the business entity.

Ms. Tompkins noted that the BOI has received several questions regarding Senate Bill 672. She advised the members that the BOI will recommend that the questions be addressed by issuing an administrative letter. Doug Gray of the Virginia Association of Health Plans (VAHP) elaborated some of his organization's concerns by noting that the change in the minimum size of a small group conflicts with current federal law. He also noted that allowing sole proprietors to enter the small group market at any time, rather than only during a limited open enrollment period as is required when purchasing a policy in the individual market, will subject the small group market to additional risks.

Staff provided the members of the HIRC with an overview of the following six bills that were introduced in the 2018 Session but were not enacted:

- House Bill 1001 (Delegate Byron), which would require carriers to establish programs to encourage patients to shop for nonemergency procedures and provide for sharing savings.
- House Bill 1268 (Delegate Toscano), which would facilitate the establishment of association health plans.

- Senate Bill 844 (Senator Dunnavant), which would allow the sale of short-term plans with a duration of up to one year.
- Senate Bill 934 (Senator Dunnavant), which would facilitate the establishment of association health plans.
- Senate Bill 935 (Senator Dunnavant), which would facilitate the establishment of health plans by bona fide associations.
- Senate Bill 964 (Senator Sturtevant), which would authorize the marketing of catastrophic health plans to a broad range of individuals.

The four Senate bills referenced above were vetoed by Governor Northam on May 18, 2018. The Governor's veto message stated concerns that the measures would place consumers at the risk of being underinsured and would fragment Virginia's federal marketplace risk pool, leading to rapidly increasing premiums.

As noted above, House Bill 1001, introduced by the Chair, 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 bill and its counterpart, Senate Bill 639, introduced by Senator Siobhan Dunnavant, 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 an in-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.

The HIRC received information on House Bill 1001 and Senate Bill 639 at its meeting on October 16, 2018. 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.

C. 2019 Rate Filings

David Shea, the BOI's health actuary, provided the HIRC with a report at its October 16, 2018, meeting 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.

D. Surprise Balance Billing

At the HIRC's July 16, 2018, meeting, Don Beatty, Deputy Commissioner for Policy and Compliance at the BOI, provided an overview of surprise balance billing, which 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. An out-of-network provider has no contract with the health carrier and no negotiated payment rate. The health carrier often limits its payment to an out-of-network provider to what it determines is a fair amount for nonemergency services, while the amount it is required to pay for emergency services is set out in § 38.2-3445 of the Code of Virginia. This section requires health carriers to provide coverage for emergency services, and, if provided out-of-network, without imposing coverage more restrictive than for services from an in-network provider, including copays and coinsurance. The section provides that individuals can be balance billed. It further provides that the health carrier is required to pay to the out-of-network provider with respect to an emergency service an

amount equal to the greatest of (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the health carrier generally uses to determine payments for out-of-network services; and (iii) the amount that would be paid under Medicare for the emergency service.

Virginia law requires, at § 38.2-5805, that HMO members be held harmless for amounts (other than applicable copayments and deductibles) when receiving services from a participating provider. There is no comparable "hold harmless" requirement for preferred provider plans offered by health insurers.

An in-network provider is contractually barred from charging the health carrier or the insured patient more than the reimbursement negotiated rate it has established by contract with the health carrier. Even at an in-network facility, a patient may have no chance to choose a network provider, as may be the case if an in-network hospital contracts with a practice group to provide certain services, such as emergency room services or anesthesiology, and that practice group is not in the insured patient's provider network. Other situations where surprise balance billing occurs primarily involve the provision of ancillary services, such as lab testing, and the transportation of patients by air ambulance services.

Mr. Beatty noted that the BOI has received 34 complaints related to balance billing of Virginia insureds since October 2017. Of these, 12 cases involve emergency room visits and 12 involve ancillary services or services received from an authorized out-of-network provider. Factors that have contributed to increases in the complaints about balance billing include narrower provider networks, lower reimbursement rates (which makes joining a network less attractive to providers), and the failure of insurers and providers to agree on payment levels for medical services.

Several states have responded to balance billing complaints by enacting legislation. Seven states have enacted comprehensive protections against balance billing. Elements of a comprehensive approach include (i) application to emergency and nonemergency situations, (ii) application to both HMO and PPO plans, (iii) requiring the health insurer and provider to hold the enrollee harmless, and (iv) prohibiting the provider from billing its patient. Such laws may also require use of a formula to determine how much a health insurer is required to pay to the out-of-network provider for the covered health care service. Some states offer a more limited approach, with elements such as limiting balance billing protection to the emergency room setting, limiting protection to HMOs, and establishing a dispute resolution process. In some states, a state agency acts as an informal arbiter between the provider and insurer to determine an acceptable level of payment.

Mr. Beatty described the Health Benefit Plan Network Access and Adequacy Model Act developed by the National Association of Insurance Commissioners (NAIC). Elements include:

- Disclosure requirements for participating facilities with nonparticipating providers. Under this provision, an enrollee may be responsible for cost-sharing obligations, such as deductibles, for out-of-network care but could not be balance billed.

- For out-of-network emergency services, the nonparticipating facility-based provider is required to include a notice to the covered patient that he is responsible for paying his applicable in-network cost-sharing amount but has no legal obligation to pay the remaining balance.
- Health carriers are required to establish a provider mediation process for payment of nonparticipating facility-based provider bills for those providers objecting to the application of an established payment rate.
- Health carriers are required to develop a written disclosure notice to advise the patient at the time of pre-certification of the possibility of the patient's being treated by an out-of-network provider even at an in-network facility. The carrier may disclose what the plan will pay for covered services provided by that out-of-network provider. The notice is required to include options available to the patient for accessing covered services from a participating provider.
- For nonemergency services, a facility is required to provide a disclosure to a covered person within 10 days of an appointment at the facility to confirm that the facility is a participating provider. The disclosure is also required to notify the person that certain professionals, such as anesthesiologists or radiologists, may not be in the person's carrier's provider network.

Mr. Beatty identified four ideas that he deemed worthy of discussion: a dispute resolution process; requiring disclosures; holding the insured patient harmless; and prohibiting provider balance billing. He also suggested that the HIRC should determine which types of balance billing should be addressed in any remedial legislation. Options include ancillary services provided at an in-network facility; emergency care, including care provided in-network and out-of-network; surgery; situations where no in-network provider is available; and a patient's knowing use of an out-of-network provider. Another issue deemed important for discussion includes cost-sharing and balance billing, which involves the question of whether cost-sharing for out-of-network services should count towards in-network deductible or out-of-pocket maximums.

Another topic that should be considered if the decision is made to restrict balance billing is whether a payment formula should be established. Options for such a payment formula, to be used in determining how much an insurer should be required to pay to an out-of-network provider for health care services, include basing a formula on Medicare reimbursement rates; on usual, customary, and reasonable (UCR) charges or rates; on the in-network payment rate; on negotiated rates; on billed charges; or on a combination of these. Yet another option is to use the All Payer Claims Database to assist in the calculation of UCR claims paid or charges billed. The HIRC was asked to consider what effect a payment formula would have on incentives for network participation. For example, if reimbursements are set high, providers may not have an adequate incentive to participate in an insurer's network.

Current federal rules require qualified health plans to either (a) count cost-sharing for an essential health benefit provided by an out-of-network ancillary provider at an in-network setting towards the enrollee's out-of-pocket maximum or (b) provide notice prior to the enrollee's receiving services at an in-network facility that the enrollee may incur additional costs to include balance billing from an out-of-network ancillary provider.

Mr. Beatty's presentation was followed by a roundtable discussion among the members of the HIRC and invited representatives of interested groups: Jill A. Hanken, Director of the Center for Healthy Communities at the Virginia Poverty Law Center; R. Brent Rawlings, Vice President and General Counsel at the Virginia Hospital and Healthcare Association; Doug Gray of the Virginia Association of Health Plans; Trisha Anest, an emergency room physician at Bon Secours Mary Immaculate Hospital and representing the Virginia Medical Society; and Julie McGarrh, Program Director for Virginia Provider Solutions at Anthem, Inc.

Ms. Hanken provided four examples of surprise billings by out-of-network providers. In some instances, patients appealed to the BOI and obtained successful outcomes. She outlined seven recommendations, which included holding the patient harmless when a physician orders ancillary services from an out-of-network lab; prohibiting balance billing by out-of-network emergency room physicians of patients who receive emergency services at an in-network hospital, but allowing balance billing for nonemergency services if the patient is provided a disclosure that the provider is not in the patient's network; prohibiting balance billing for facility charges when an in-network physician provides services at a facility that is not in the patient's insurer's network; requiring use of the prudent layperson standard in determining when an insurer is required to cover emergency medical care, as when patients are told they need to stay in the hospital for follow-up care; strengthening the definition of network adequacy, with time and distance standards, for purposes of determining whether a managed care plan is eligible for approval; and prohibiting changes in a provider network during a year.

Mr. Rawlings stated that a balanced approach is needed, and he cautioned that there is no easy fix. Providers also want a "friction-free" environment, and the examples cited are exceptions to the rule. Hospitals have financial counselors to assist patients through the process when issues arise. In response to questions by Delegate Byron, he noted that providers try to obtain preauthorization when referrals are made to out-of-network labs. As to contracting with out-of-network physicians, he noted that hospitals have a duty to provide services and at times that duty can best be met by open staffing, under which the facility contracts with outside doctors. Senator Wagner questioned the current system where there is no limit on the amount an out-of-network provider can set as its charges and consequently can balance bill a patient.

Mr. Gray observed that part of the challenge is that providers are not taking responsibility for what happens within their doors, where they have a monopoly over what occurs. He labeled the practice of contracting with some out-of-network practice groups as intentional and willful. He noted that private equity firms are buying up emergency medicine practice groups because they are viewed as a profit center. As to the issue of lab work being sent to out-of-network providers, he asserted that it is done because the referring providers have financial incentives to do so. While agreeing that providers may stay outside of a carrier's network because the carrier does not offer to pay them what they are asking for, Mr. Gray noted that if they were paid what they wanted, insurance premiums would rise. He echoed Mr. Beatty's comment that enrollees covered by an HMO are required to be held harmless for emergency services provided by out-of-network providers. In such cases, the providers are not entitled to payment of the full amount they charge, and the parties may try to negotiate a result.

Senator Dance asserted that hospitals and insurers need to work it out, and that patients need a better deal. In response to Delegate Filler-Corn's question of how a carrier can be found to provide network adequacy when an in-network facility may lack in-network emergency room physicians, Mr. Gray observed that the network may have such physicians at different facilities.

Dr. Anest noted that as an emergency room (ER) physician she does not know the insurance status of her patients. She noted that in some instances a database has been used to determine what is a reasonable payment, which is what she wants doctors to receive. A question by Delegate Byron elicited the statement that most ER physicians are in-network.

Mr. Gray noted that historically, surprise balance billing arose when there was only one hospital in a metropolitan area, because physicians elected not to contract with a hospital that had such leverage. Citing the examples of Williamsburg and Fredericksburg, he noted that the practice ended when new hospitals entered the market and ended the monopoly facility's leverage.

Ms. McGarrh asserted that balance billing is essentially an adequacy issue. She cited the example of receiving a $3,687 bill for urinalysis tests that can be done for $50. Senator Wagner characterized the practice as fraud. She noted that providers may refuse to participate in a network if they believe the reimbursement rates are too low. She stated that opiate treatment providers have refused to join networks because they have the ability to collect from patients more than they would if they contracted with carriers.

Senator McDougle urged interested groups to agree on a solution, and he suggested that if they failed to do so, the General Assembly would develop an approach that would not make them happy. He doubted that Ms. Hanken's recommendations would be adopted as proposed, but he cautioned that we will not continue to do what we are doing today. Senator Wagner concurred, adding that the certificate of public need (COPN) process has outlived its usefulness and that there are systemic problems driving up health care costs that need to be corrected.

Following the HIRC's suggestion that interested parties meet and determine if they could develop a solution that would protect patients from surprise balance billing, the BOI arranged their first meeting on August 13, 2018. 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.

At the following HIRC meeting on October 16, 2018, staff reported that as of the conclusion of the October 15 meeting the interested groups had made a great deal of progress but had 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 unless 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 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, set out in § 38.2-3445, 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.

Mr. 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 § 38.2-3445 the Code of Virginia (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, and would receive protections that the carrier would send payments directly to the provider and not to the patient, would 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 would 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.

Mr. Gray 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 for 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 the selection of an appropriate site for receipt 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, by guaranteeing reimbursement payments to providers at higher levels these provisions 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.

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.

The HIRC did not take action on any of the balance billing proposals at its October 16 meeting.

E. Charity Care Data Collection Efforts

The second enactment of House Bill 2101 of the 2017 Session, which was patroned by the Chair, directs the Commissioner of Health to prepare an analysis of charity care that each medical care facility provided to indigent persons. The report, which is due by November 1, 2018, 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. The analysis will also include an assessment of the number of patients to whom charity care was provided, the specific services delivered to patients that are reported as charity care recipients, and 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).

At the HIRC's July 16, 2018, meeting, Erik Bodin, Director of the Certificate of Public Need program in the Virginia Department of Health (VDH), reported on the status of data collection efforts, the analysis methodologies, and the timetable for completing the report by its November 1, 2018, due date.

Provisions of House Bill 2101 that amend § 32.1-276.5 of the Code of Virginia to impose charity care reporting requirements appear to be narrower in scope than the reporting required by the bill's second enactment clause. The amended § 32.1-276.5 applies to every medical care facility for which a COPN is issued with an associated condition to provide a level of charity care. In contrast, the bill's second enactment applies to "each medical care facility." Mr. Bodin reported that the State Health Commissioner has sent letters to all 103 licensed hospitals requesting charity care data by July 15, 2018. Data requests have also been submitted to all licensed outpatient surgical hospitals and outpatient facilities with a COPN, with a due date of August 18, 2018.

However, not all licensed hospitals or outpatient facilities have a COPN with a charity care condition. The VDH has asked those facilities for which there is no COPN with a charity care condition to report the data voluntarily, and Mr. Bodin noted that all facilities that have been asked to respond appear willing to comply with the request.

Mr. Bodin noted that the VDH is expanding its contract with Virginia Health Information (VHI), which maintains the All Payer Claims Database, to include data on outpatient facilities. The VDH also has commenced the process of updating its COPN regulations in order to establish how the new charity care reporting requirements will be applied.

The VDH reported that it expected to complete data collection by mid-August. Between mid-August and mid-September, the agency will complete its data analysis and prepare a draft report. From mid-September through mid-October, VDH plans to conduct an internal review of the draft report and prepare the final report in order to submit the final report to the General Assembly by November 1, 2018.

F. Health Care Price Transparency

James Sherlock, a retired naval officer and resident of Virginia Beach, provided the HIRC with a report comparing health care cost transparency provisions in Virginia with those in New Hampshire. Mr. Sherlock noted that New Hampshire's population is much smaller than that of the Commonwealth. Two other differences are the fact that New Hampshire disbanded its certificate of need provisions in 2016 and that it does not have any health insurers that are controlled by a health care provider.

In Mr. Sherlock's view, Virginia health care costs are better concealed than national secrets, and the lack of transparency results in disparities. Moreover, Virginia law favors health care providers in their negotiations with insurers. Factors contributing to this result include the ownership of some insurers by hospital systems and the COPN requirements, which are immune from antitrust challenge as a result of the state action doctrine.

Since 1997 New Hampshire has required health insurers to submit data as a condition of doing business. While New Hampshire provides consumers with all of the information in its all-payer cost database that is not restricted by federal HIPPA requirements, Virginia prohibits the disclosure or reporting of provider-specific, facility-specific, or carrier-specific reimbursement information from its All-Payer Claims Database.

New Hampshire's health care data information is accessible through its NH HealthCost internet portal, which was developed by the state's Insurance Department. The site allows consumers to estimate total payments by an insurer for medical and dental services and procedures for specific facilities and professionals, on the basis of a person's insurance company and plan type. New Hampshire's site also provides information on discounts that providers give to uninsured patients.

VHI's website shows the median of the charges billed for a medical procedure by specific providers within a region, but not the amount paid by insurers to the provider for the medical

procedure. Mr. Sherlock stated that health care costs are lower in New Hampshire than in Virginia, and he offered several recommendations to bend the cost curve. These include increasing transparency, eliminating the COPN requirements, requiring all firms to report data, and repealing the prohibition on traceability of cost data. He contends that the COPN requirements have established and sustained hospital control of ambulatory surgical centers (ASCs). He urged the Commonwealth to redress the demonstrable shortage of ASCs by issuing COPNs to applicants that are not affiliated with existing hospitals.

Senator Wagner asked the audience if anyone would oppose an increase in transparency of health care costs. While no one raised an objection at that time, later in the meeting Mr. Gray observed that New Hampshire's data shows the median of health care prices rather than a fixed amount that will be charged for a procedure, and that Virginia's database uses an adequate proxy. In his view, New Hampshire has spent funds to create their web-based tool and advertise more aggressively. If the reimbursement rates that are negotiated by each provider and insurer are posted, costs will increase as those providers who are paid below the median demand that their reimbursements be increased to the higher levels received by other providers. Moreover, enrollees currently have the ability to find the negotiated reimbursement amounts for in-network providers.

G. Federal Developments and Options for the States

Jim Young, Policy Advisor at the BOI, reported at the HIRC's May 24, 2018, meeting on CMS' Notice of Benefit and Payment Parameters dated April 19, 2018 (the Notice). The Notice indicated the intention of CMS to introduce changes to reduce regulatory burdens and simplify some eligibility and enrollment processes for consumers.

The Notice identifies three ways a state may amend the EHBs in its benchmark plan: adopting a benchmark plan of another state; replacing one or more categories of EHBs in its own benchmark plan with those of another state; or creating a new benchmark plan with different EHBs. However, a state's flexibility in exercising any of these three options is subject to two limitations. First, the new benchmark plan is required to provide a scope of benefits that is equal to, or greater than, the scope of benefits provided under a typical employer plan. Second, the new benchmark plan must not exceed the generosity of the most generous among the comparison plans from the 2017 plan year. The deadline by which a state may make such a change to its benchmark plan for 2020 is July 2, 2018.

Other federal changes outlined in the Notice include:

- Allowing the U.S. Department of Health and Human Services (HHS) to adjust the 80 percent medical loss ratio (MLR) in a state in order to help stabilize the individual market.
- Eliminating, through the Federal Tax Cuts and Jobs Act of 2017, the tax penalties for individuals who fail to have health insurance that meets the standards of minimum essential coverage.
- Expanding the hardship exemption under guidance issued by CMS. Persons qualifying for a hardship exemption are exempt from penalties for not having minimum essential coverage and are eligible to purchase catastrophic coverage. Under the CMS guidance, individuals can now apply for a hardship exemption if they live in an area where there are no marketplace plans or if only a single carrier offers marketplace plans; if they cannot find

an affordable marketplace plan that does not cover abortion; or if their personal circumstances, such as not having access to a plan that covers the specialty care they need, make it difficult to buy a marketplace plan.

- Allowing states to request CMS to reduce risk adjustment transfers in the individual or small group market by up to 50 percent beginning with the 2020 benefit year.
- Extending the transitional policy for one additional year, to December 31, 2019, in order to allow for the transition to fully ACA-compliant coverage in the individual and small group markets.
- Extending the term of short-term limited duration plans from three months to one year, under proposed HHS regulations.
- Allowing states to apply for a State Innovation Waiver under §1332 of the ACA. The waivers incentivize states to try innovative strategies for providing their residents access to health insurance plans that contain the basic ACA protections. The process for applying for a § 1332 waiver includes enacting state legislation and preparing appropriate actuarial and economic analyses. Mr. Young reported that four states have applied for a § 1332 waiver for a reinsurance program and that 30 states have some type of waiver application pending with HHS.

Mr. Young also briefed the HIRC on the Virginia Market Stabilization Grant Project. The BOI's grant application is currently pending at CMS. The proposed project encompasses several projects that assess the benefits Virginia consumers receive for the premiums they pay and look at ways to improve accessibility and affordability of coverage in the individual market. The BOI and its consulting actuaries will develop modeling tools that can be used to assess the expected impact of various policy changes on premium, enrollment, and market morbidity and allow BOI to summarize plan information by market, entity, county, rating area, and other criteria across the Commonwealth. Funds from the grant are also proposed to be used to prepare an innovation waiver application for a state reinsurance program for Virginia.

Finally, Mr. Young noted that rates and forms are required to be approved for all Exchange filings by August 22, 2018, and that open enrollment begins November 1, 2018, for policies to be in effect in 2019.

H. 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.

III. CONCLUSION

The HIRC appreciates the efforts of everyone who contributed to its work in 2018 and looks forward to working with interested persons as it continues to examine issues concerning the Commonwealth's health insurance market.

Materials provided by speakers at the HIRC's meetings in 2018 may be found on the HIRC's website at http://dls.virginia.gov/commissions/hir.htm?x=mtg.