COMMONWEALTH of VIRGINIA

Office of the Governor

Daniel Carey, M.D.
Secretary of Health and Human Resources

January 21, 2020

MEMORANDUM

TO: The Honorable Ralph S. Northam
Governor of Virginia

Senate Finance & Appropriations Committee

House Appropriations Committee

FROM: Daniel Carey, MD

SUBJECT: Report pursuant to Item 281 F. of the 2019 Appropriation Act

The Secretary of Health and Human Resources, in collaboration with the Secretary of Administration, Secretary of Finance, and State Corporation Commission (SCC), shall 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 shall include: 1) staff from the House Appropriations and Senate Finance Committees and representatives from such state agencies as the Commission and Secretaries deem appropriate, and 2) relevant stakeholders, including but not limited to, the Medical Society of Virginia, Virginia College of Emergency Physicians, Virginia Hospital and Healthcare Association, Virginia Association of Health Plans, Virginia Poverty Law Center, and National Patient Advocate Foundation. The workgroup shall include in its report the fiscal impact of each option considered and the impact on provider networks. The workgroup also shall include in its report recommendations for future legislation for consideration by the General Assembly. The SCC shall provide analytical and actuarial services pursuant to the workgroup's analysis and development of a proposal, as needed. The workgroup shall protect any proprietary and confidential data of any health plan, healthcare provider, or third party administrator in its final report. The workgroup shall report its recommendations to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by November 15, 2019.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-7765.

DC/kb

Enclosure

Report of the Virginia Balance Billing Work Group

To the Governor and Chairmen of the House Appropriations and Senate Finance Committees

December 31, 2019

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Executive Summary

The purpose of this report is to provide an analysis and present findings from the Virginia Balance Billing Workgroup to address the practice of balance billing. The Secretary of Health and Human Resources, as directed by the General Assembly established this Workgroup pursuant to the 2019 Appropriation Act, Item 281 F, which states:

> *The Secretary of Health and Human Resources, in collaboration with the Secretary of Administration, Secretary of Finance, and State Corporation Commission (SCC), shall 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 shall include: 1) staff from the House Appropriations and Senate Finance Committees and representatives from such state agencies as the Commission and Secretaries deem appropriate, and 2) relevant stakeholders, including but not limited to, the Medical Society of Virginia, Virginia College of Emergency Physicians, Virginia Hospital and Healthcare Association, Virginia Association of Health Plans, Virginia Poverty Law Center, and National Patient Advocate Foundation. The workgroup shall include in its report the fiscal impact of each option considered and the impact on provider networks. The workgroup also shall include in its report recommendations for future legislation for consideration by the General Assembly. The SCC shall provide analytical and actuarial services pursuant to the workgroup's analysis and development of a proposal, as needed. The workgroup shall protect any proprietary and confidential data of any health plan, healthcare provider, or third party administrator in its final report. The workgroup shall report its recommendations to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by November 15, 2019.*

The Balance Billing Workgroup, or Workgroup, was composed of a diverse group of stakeholders, including members from the following state agencies, organizations, and groups:

Aetna
Anthem
Commissioner of Insurance and other representatives of the Bureau of Insurance
Department of Human Resource Management
Department of Medical Assistance Services
Hospital Corporation of America
House Appropriations Committee
Joint Commission on Health Care
Medical Society of Virginia
National Patient Advocate Foundation
Office of the Secretary of Administration
Office of the Secretary of Finance
Office of the Secretary of Health and Human Resources
Senate Finance Committee
Sentara/Optima
Virginia Association of Health Plans
Virginia College of Emergency Physicians
Virginia Commonwealth University
Virginia Hospital and Healthcare Association
Virginia Poverty Law Center
Virginia Society of Anesthesiologists
Virginia Society of Plastic Surgeons

Various representatives from related industries including insurance carriers, physician member organizations and patient advocates attended meetings and contributed to the discussions.

The Workgroup first met on August 28, 2019 and then on September 18, 2019. Secretary of Health and Human Resources Daniel Carey, MD and Deputy Secretary of Health and Human Resources Marvin Figueroa lead the meetings. Notes were taken during each meeting and subsequently provided to the members. In the first meeting, the Workgroup examined the federal landscape of balance billing and payment standard options. Representatives from the National Governor's Association National Center for Best Practices and Georgetown University facilitated the discussion. The second meeting examined the 2019 Session proposed balance billing legislation and the impact on state plans. The Workgroup asked that three policy options be analyzed by the Department of Human Resource Management (DHRM) and the Bureau of Insurance (BOI) including the provisions in HB 1714 (2019), HB (2544) or a singular payment standard that does not fall below 200% of Medicare. The Workgroup did not reach consensus for a specific recommendation.

Introduction

Definition of Balance Billing

A balance bill or surprise medical bill occurs when a consumer is billed for the difference between what an insurer pays for a covered service and what the provider is charging for the service. In most cases it occurs because the provider does not have a contract with the consumer's insurance plan. Balance billing typically occurs in three possible scenarios:

1. Emergency Situation: An insured consumer is in an emergency situation and receives services at an in-network facility with providers who are out of network, or receives services at an out-of-network facility.
2. In-Network Facility: An insured consumer receives a nonemergency inpatient or outpatient service at an in-network facility, but some of the providers are out of network, or an in-network provider orders an ancillary service, such as laboratory testing, radiology or diagnostic imaging, from a provider who is out of network.
3. Ground Medical Transport: An insured consumer is transported in an emergency situation or between facilities in a nonemergency situation by a ground medical transport provider that is out of network.

Current Virginia law

Section 38.2-5800 of the Code of Virginia defines basic health care services to include emergency services and section 38.2-3451 of the Code of Virginia requires payors to provide benefits for emergency services as an essential health benefit.

An out-of-network provider is not contracted with the health plan carrier, meaning there is no pre-negotiated payment rate. Payment standards for out-of-network emergency services are set out in Virginia statute and mirror current federal rules. Section 38.2-3445 states that "If emergency services are provided out-of-network, requirements and limits cannot be more restrictive than those that apply to an in-network provider." In other words, an individual would pay the usual cost-sharing under their plan agreement. However, if the provider charges exceeded the carrier payment, the consumer may be held responsible for the remaining balance. Some carriers negotiate payment to remove covered person responsibility however if that does not occur, then providers may bill the covered person for the remaining balance or choose not to balance bill.

It is the BOI's interpretation of the above requirement that if a carrier would pay an in-network provider directly, the carrier must also pay the out-of-network provider directly for emergency services received in a hospital emergency department. This relates to timeliness of payments to providers.

Further, the definition of emergency services and emergency medical conditions (Section 38.2-3438) requires prudent layperson standards. Under federal law, the term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."[1]

Reimbursement under current law

The Virginia formula for reimbursement of out-of-network emergency services is the greatest of three amounts:

- The median amount negotiated with in-network providers for the emergency services;
- The usual, customary and reasonable amount; and,
- The amount that would be paid under Medicare for the emergency service.

These requirements mirror the federal rules that a state may only set its own reimbursement or a carrier may only pay a different amount if the state law prohibits balance billing or the carrier

[1] https://www.law.cornell.edu/uscode/text/42/300gg-19a

holds themselves responsible to pay the balance. For this situation, federal rules require a carrier to provide an enrollee adequate and prominent notice of their lack of financial responsibility, even for emergency situations. [2]

How Balance Billing Impacts Virginia Consumers

The BOI reports that since July 2017, there have been 78 complaints related to balance billing for emergency services. Additionally, there have been 30 cases related to air ambulance complaints and 28 cases where there was no jurisdiction such as self-funded insurers, federal employees and coverage issued out-of-state. The majority of the 78 balance billing complaints relate to bills from out-of-network emergency room physicians at an in-network facility.[3] Services commonly impacted include plastic surgery, pathology, emergency services, anesthesiology and radiology.

It is important to note that while the BOI receives complaints, many more consumers may receive bills, and may not recognize that this is due to out-of-network services, or know that they can file complaints.

Settings Where Surprise Billing Occurs

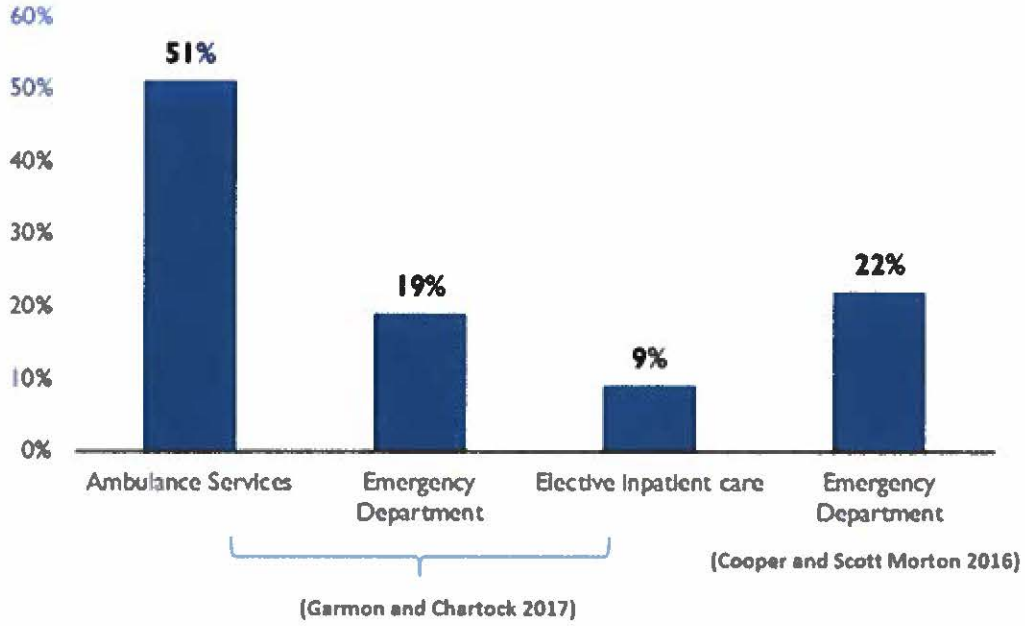
The following chart demonstrates nationally, the incidences of surprise medical billing in various settings. It should be noted that there are two references to emergency departments. To distinguish, the 19% refers to outpatient emergency services including those in an out-of-network emergency department. The 22% refers to emergency department services. [4]

[2] Bureau of Insurance Report to the Surprise Medical Billing Workgroup, August 28, 2019.

[3] Bureau of Insurance Report to the Surprise Medical Billing Workgroup, August 28, 2019.

[4] Brookings Institute, *State Approaches to mitigating surprise out-of-network billing, Loren Adler, et al. February 19, 2019.* https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/

Figure 1. Percentage of Visits Leading to a Potential Surprise Out-of-Network Bill



Source: Garmon and Chartock 2017; Cooper and Scott Morton 2016

Note: For the Garmon/Chartock figures, 19% represents the % of outpatient ED cases, including those to an OON ED, that could result in a potential surprise balance bill.

USC Schaeffer BROOKINGS

Workgroup Summary – August 28, 2019

Representatives from the National Governor's Association (NGA) research and development firm National Center for Best Practices and Georgetown University facilitated the discussion at the August 28th meeting. The Group heard presentations on both the Virginia and national landscape.

While several objectives were explored as part of the Workgroup charge, the Workgroup agreed on the common goal of consumer protection. The group was asked whether they wanted to include non-emergency services as part of its charge. The group determined it wanted to focus efforts on where the biggest issue lies in the Commonwealth, which was not clear at the time.

There was discussion of possible federal action and the potential burden of following federal policy for one set of services and state policy for the other. It was noted that waiting for the federal government to act will negatively impact patients, and that Virginia could account for potential federal action with language.

The second part of the discussion centered on the reimbursement formula. VAHP, on behalf of its member plans, has stated that if a reimbursement formula is set higher than the current health plan negotiated rate, health care and insurance costs will increase for members. The payors that have the largest number of members have the best negotiated provider discounts. Providers indicated a strong interest in more transparency (which they state is challenging with an in-network rate standard) for without which undermines their negotiating position.

Workgroup Summary – September 18, 2019

The BOI presented on current balance billing practices in Virginia. Balance billing provisions in current Virginia law focus on the fully-insured markets, which include approximately 22% of Virginia residents. Self-funded insurance plans, governed by the U.S. Department of Labor under ERISA, constitute approximately 35% of the market share. VAHP, on behalf of its member plans, stated that fully-insured and self-insured plans utilize the same provider network. Therefore, any negative impact on fully-insured business could extend to self-funded business. Further, a prohibition of balance billing on facilities could impact those covered by self- insured plans as a result of Emergency Medical Treatment and Labor Act (EMTALA) requirements, which requires emergency rooms to serve individuals regardless of insurance status or condition.

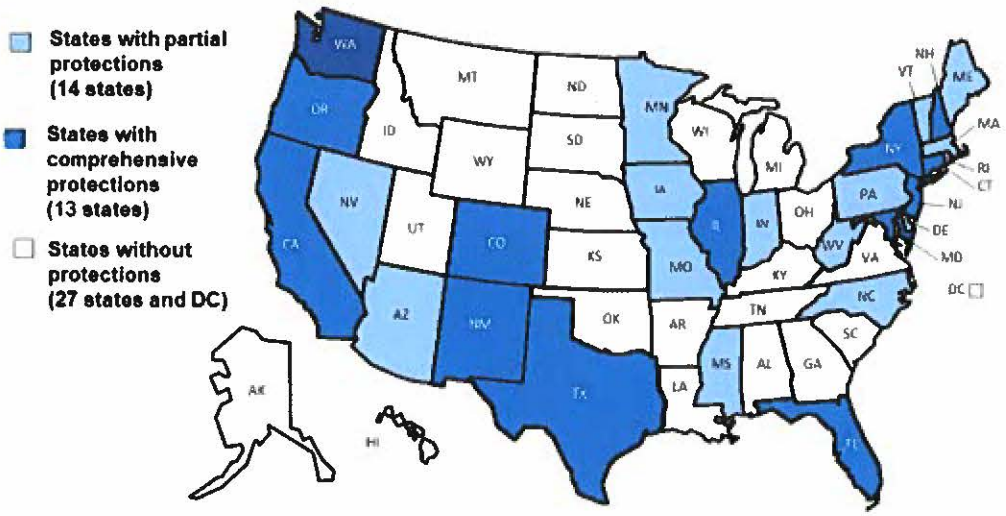
While specific services comprise a significant amount of balance billing, contributing factors also include narrow networks, provider difficulty understanding what networks they are in, and lack of contracting between payors and providers.

Of the provisions discussed, the group expressed interest in hold harmless provisions, and pairing a reimbursement amount with dispute resolution. Self-insured opt-in was also discussed as it could be helpful to the payorsby mitigating concerns of potential network impacts. The group also considered that Virginia could create a payment standard with the backstop of an arbitration process. The Virginia Hospital and Healthcare Association (VHHA) representatives indicated that this hybrid approach is helpful and having a backstop would help provide more equal negotiating leverage.

In this meeting the Workgroup discussed the bills introduced in the 2019 Virginia legislative session as well as a Medicare percentage as a payment standard.

The National Landscape

State Laws Protecting Consumers Against Balance Billing, July 2019



Broadly speaking,

- Twenty-eight states have taken action to prevent balance billing
- Thirteen states have passed comprehensive legislation
- At least six states passed provisions in 2019
- Many more introduced bills

There are several types of strategies to address balance billing, which fall into four major categories:

1. Setting (Emergency Department and Non-emergency care)
2. Type of Managed Care Plan (HMO and PPO)
3. Type of protections (Hold Harmless and Provider Prohibition)
4. Reimbursement Method (Payment Standard and Dispute Resolution).

State strategies to address balance billing can be considered by level of comprehensiveness. The chart below illustrates states that have passed legislation in 2019 and corresponding comprehensiveness provisions.

State	Setting		Type of Managed Care Plan		Type of Protection		State-Specific Method for Payment	
	Emergency Department	Nonemergency Care in Network Hospital	HMO	PPO	Hold Harmless	Provider Prohibition	Payment Standard	Dispute Resolution Process
Colorado	✓*	✓*	✓	✓	✓	✓	✓	**
Missouri	✓*		✓	✓		✓		
Nevada	✓		✓	✓	✓	✓	*	✓
New Mexico	✓	✓*	✓	✓	✓	✓	✓	
Texas	✓	✓*	✓	✓	✓**	✓		✓***
Washington	✓	✓*	✓	✓	✓	✓		✓**

Download data

The Virginia Workgroup conversation focused on emergency services, hold harmless provisions, and reimbursement options.

Options for Protecting Consumers

1. A balance billing prohibition would prohibit out-of-network providers from balance billing consumers in surprise out-of-network scenarios.
2. A hold harmless provision holds consumers harmless from having to pay any surprise medical bills. This often limits the consumer responsibility to in-network cost sharing but can be less protective than a prohibition as standalone protection as consumers may not be aware that they are protected and may pay the balance anyway.
3. Disclosure requirements require providers, facilities, and/or insurers to disclose information such as network status or possible cost sharing responsibilities to consumers. This is not protective as a singular strategy, however, as the disclosure may explain risk without definitive information about status of provider or the consumer may not understand what the disclosure means .

The Group's study of state approaches demonstrated that hold harmless and disclosure requirements are not comprehensive, but can be first steps to build upon.

Options for Determining Provider Reimbursement

1. A reimbursement benchmark sets a specific reimbursement for surprise out-of-network services. Common reimbursement benchmarks have included percentage of Medicare (Ex: 125-150%), percentage of contracted rate and a "commercially reasonable" rate. The commercially reasonable rate is seen as a more relaxed standard and is predominantly determined by the provider.
2. Independent Dispute Resolution (IDR) is a process for assisting payers, providers, and consumers in coming to an agreement on a fair rate of payment. Independent Dispute Resolution can be paired with reimbursement standards as a back up in case of

disagreement between the provider and carrier. Common types of dispute resolution are baseball style or mediation. Typically, if a party (provider, carrier, or even consumer) wants to dispute they can go to the Insurance Commissioner to initiate the process. However, states have found that when IDR processe are in place, providers and insurers often reach agreement before reaching arbitration.

3. Assignment of Benefits (AOB) allows consumers to authorize out-of-network providers to receive reimbursement directly from insurers. Some states have tied surprise medical billing prohibitions to AOB processes to remove consumers from the reimbursement process. [5]

Other State Examples

Maryland has an AOB law. When the patient gives a preferred provider an assignment of benefits, the carrier sends payment for the allowed amount for the covered service, less any applicable copayment, coinsurance or deductible amounts, directly to the preferred provider. Some carriers will not accept an AOB provided by the patient/insured to a non-network provider, unless state law requires them to do so. In this case, the carrier sends a check for the allowed amount, less any applicable copayment, coinsurance or deductible amounts, to the insured. The insured is responsible for paying the non-network provider all amounts due, including the allowed amount and the balance bill, if any.[6] It should also be noted that Maryland regulates hospital rates as well as non-participating provider fee schedule, which is not what occurs in Virginia.

The acceptance of AOB by carriers for non-network providers has been the subject of great debate. Physicians, particularly hospital-based physicians, maintain that when a carrier does not accept an AOB it is difficult to collect the allowed amount from the patient, thus increasing administrative costs and the charge for the health care services rendered by the physician. Carriers respond that without the ability to reject an AOB for non-network providers, particularly hospital-based physicians, physicians will not have an incentive to join the carrier's provider network and costs for all insureds will increase. Others note that balance billing unfairly increases cost for insureds.

New York tied balance billing to AOB, and requires plans/providers to inform consumers of AOB and send them the form. AOB can be a vehicle for advancing further balance billing protections as a form of transparency.

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[5] National Governor's Association presentation to the Surprise Medical Billing Work Group, August 28, 2019.

[6] Maryland Insurance Administration, *Assignment of Benefits,* 2010. https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/report-assignmentofbenefits12-15-10.pdf

Washington State selected specific services for prohibitions: providers or patients can initiate arbitration. Additionally, the All Payer Claims Database (APCD) is used to determine rates, with a minimum reimbursement of 150% of Medicare. There is a self-insured opt-in which means that the employer of an ERISA group can opt-in.

A bill passed this year in New Mexico included a prohibition on balance billing for both emergency and non-emergency services for all provider types. The reimbursement rate is 150% of Medicare and New Mexico uses Fair Health, an independent database, to determine rates (as there is no APCD).

In Texas, freestanding emergency rooms have a high frequency of balance billing. Texas has a 10-year history in which multiple iterations of laws have passed. Recently passed legislation applies to both PPOs and HMOs, all fully insured consumers, and all provider types (including emergency and non-emergency). If a claim is filed through a hospital, it goes to mediation. If it is filed through a provider, it goes to a baseball style arbitration. The Texas Attorney General has the authority to bring civil action and the Medical Board and Department of Insurance may issue disciplinary actions against providers and insurers, respectively.

The discussion of potential occurrence of premium increases with balance billing protections has not been prevalent in many other states because many have protective laws in addition to the balance billing prohibition. Some states also have reporting requirements on insurance networks, premiums, costs, etc. Some have sunsets, which trigger a re-evaluation for continuation of the program. Premium increases were not a major part of the debate in Texas as they are in Virginia.[7] In a case analysis of the implementation of New York's balance billing law (passed in 2014), conducted by Georgetown University Center on Health Insurance Reforms in 2019, regulators have not yet reported an inflationary effect on annual premium rate filings due to the law.[8]

Gaps in State Regulation

While states have made strides to address the impact of surprise balance billing, there are still significant gaps in state regulation. There are several states without laws protecting consumers, and states that do not have jurisdiction over self-funded plans, air ambulance services, and when services are received in another state.

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[7] National Governor's Association presentation to the Surprise Medical Billing Workgroup, August 28, 2019.

[8] Corlette, Sabrina, and Hoppe, Olivia, Georgetown University Center on Health Insurance Reforms, *New York's 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study,* (May, 2019), p. 10 Retrieved from: https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9

How Virginia Efforts Compare to Other States

The BOI reported that Virginia proposals have had elements of and are generally consistent with other states legislative approaches. There was general agreement that the Group was focused on addressing emergency settings only, and examining hold harmless provisions and reimbursement options. The Workgroup did contemplate a modified form of dispute resolution that would provide that in the instance of dispute, the BOI would review the case in order to verify whether the payment met the standard set forth under Virginia law.

Other states have both emergency and non-emergency provisions, and states have done an incremental process, by sectors. Hold harmless provisions, which means that a consumer will not be held responsible for paying the balance of a bill, is the core of what protects consumers; however, as a standalone policy, it does not prevent providers from billing. Dispute resolution could be used in some cases with questions of payment standard.

There was discussion in the Workgroup about different approaches to dispute resolution in other states and what information is used. Some states have an in-house arbiter, others use information brought to them. Often the pay structure in arbitration is that the one party is held liable for all of the costs. However, the cost of the arbitration itself can be split between stakeholders. Some states are prescriptive about what the arbiter can examine, the rates, and what the terms should be. Some states take into consideration: APCD data, co-occurring disorders, pre-existing conditions, unusual cases, and rural travel. [9]

California law includes a back up to the payment standard. New York is seen as an arbitration state and may have a time period in which payment must occur. Some states have a formal process, but require an informal process first. Some have in-state arbitration officials and others are independent. New Jersey and New York have consumer disclosures- examples include: in vs. out-of-network and what cost-sharing consumers may face. Doctors do not have information regarding insurance status. New York carefully selected disclosure requirements so that the stakeholder has the ability to disclose whereas Texas discloses which hospitals have which in-network providers.

As noted previously, Virginia discussions have contemplated potential cost and network impacts to state employee health plans. This has not been found to be an item of significant discussion in other states.

[9] National Governor's Association presentation to the Surprise Medical Billing Workgroup, August 28, 2019.

Federal Activity

Balance billing was a prominent issue on Capitol Hill in 2019. There were 6 pieces of legislation involving balance billing and prescription drug prices. Both issues continue to move with bi-partisan support and cover mainly specific circumstances where balance billing takes place. None cover road ambulances and only one Senate bill looks at air ambulances. Both the House and Senate have bills that ban balance billing and utilize median in-network rates. Proposals such as Senate Bill 1531 sponsored bv Senators Cassidy and Hassan, and HR. 3630 from Representatives Pallone and Walden are bi-partisan sponsored and include a hybrid approach that use both median in-network rates and Independent Dispute Resolution (IDR) as an option to address reimbursement.

It is expected that Congressional committees will continue to pursue balance billing legislation, however, efforts could be hampered by stakeholder disagreement and a desire to address prescription drug prices first.

Evaluation and Actuarial Study of Virginia Legislative Options

Bureau of Insurance (BOI) and the Department of Human Resource Management (DHRM)

The Workgroup discussed several options for a Virginia proposal to be introduced during the 2020 General Assembly session. The Workgroup began with a scan and analysis of two bills that were introduced and amended in the 2019 General Assembly session. Those were HB 1714 and HB 2544. The bills were put forward by health care providers and the insurance industry, respectively. Below is the analysis provided by the BOI and its actuarial consulting firm, Oliver Wyman, on each bill as a policy option.

HB 1714

Under HB 1714, current law would be revised to prohibit non-participating providers providing emergency services with the Commonwealth from balance billing a covered person, and define the benchmark reimbursement amounts that non-participating facilities and health care professionals would be required to accept as payment in full when providing emergency services in the Commonwealth as the greatest of the following:

1. The amount negotiated with in-network providers for the emergency service, or, if more than one amount is negotiated, the median of these amounts;
2. The amount for the emergency services calculated using the same method the payor generally uses to determine payments for out-of-network services, such as the usual, customary, and reasonable amount;
3. The amount that would be paid under Medicare for the emergency service; and,

4. If out-of-network services are provided (a) by a health care professional, the regional average for commercial payments for such service, or (b) by a facility, the fair market value for such services.

Current law requires that the payor provide benefits, inclusive of any cost-sharing paid by the covered person, in an amount equal to the greatest of the first three items listed above. HB 1714 would add the fourth criteria. Therefore, in evaluating the impact that this policy option would be expected to have on allowed claims, the allowed amount currently on claim records for emergency services delivered by non-participating providers within the Commonwealth was replaced with the amount determined under the fourth item above (when taking into consideration payment modifiers), only if that amount was greater than the allowed amount currently on the claim record.

Payors were not able to identify which claims were associated with single case agreements, emergency-only participation agreements, or rental network agreements. Therefore, these claims were considered as services delivered by either a participating or nonparticipating provider based on how payors populated the network indicator field in the claims data provided for the analyses, which presumably was consistent with how the field was populated in their data warehouse.

Healthcare Professionals
HB 1714 defines the regional average for commercial payments as:

The fixed price, based on data submitted by data suppliers in 2017 pursuant to subdivisions B1 and 2 of §32.1-276.7:1 and reported to the Commission's Bureau of Insurance by the nonprofit services organization that is determined on the basis of the amounts paid to and the amounts accepted by health care providers, from payors by category of providers for comparable out-of-network emergency services, identified by codes, in the community where the services were rendered, including amounts accepted under single case agreements, emergency-only participation agreements, and rental network agreements. Regional average for commercial payments determinations do not include amounts accepted by providers for patients covered by Medicare, TRICARE, or Medicaid.

Data from the APCD was not able to be used for these analyses for the reasons described therein. As such, the commercial data provided by payors was used both to develop the regional averages and for assessing the impact of those regional averages on allowed claims. The regional averages were developed based on comparable services, defined as claims for emergency services with the same CPT/HCPCS (Current Procedural Terminology/Healthcare Common Procedure Coding Systems). In discussing with the BOI how these regional averages should be calculated, Oliver Wyman was informed that proponents of HB 1714 intend for the regional average for a given

CPT/HCPCS to be calculated as the straight average (i.e., unweighted average) of the median allowed amount for each payor, within the region. As an example, if three payors offering coverage within the Central Region provided data for the analyses, the regional average for CPT code 71045 for the Central Region was calculated as:

> Median Allowed Amount for Carrier A in the Central Region for CPT 71045 = X
> Median Allowed Amount for Carrier B in the Central Region for CPT 71045 = Y
> Median Allowed Amount for Carrier C in the Central Region for CPT 71045 = Z
> Regional Average for CPT 71045 for the Central Region = (X+Y+Z) / 3

When calculating each payor's median, claims for both participating and nonparticipating providers were used, after limiting the claims to only those for services provided by health care professionals, which met the previously described definition of emergency services. As discussed above, prior to determining the median amount for each payor, CPT/HCPCS and region, the allowed amount on any claim record containing a payment modifier was first adjusted to reflect an "unmodified" value, and the median allowed amounts for each CPT/HCPCS code, region, and payor were then developed using the "unmodified" allowed amounts.

HB 1714 indicates that the regional averages should be calculated for each "category of provider" however due to an inconsistency in how payors submitting claims data for the analyses populated the provider specialty field, this field could not be used. Therefore, the carrier medians and in turn regional average for a given CPT/HCPCS code were based on all claims for that CPT/HCPCS code within the region, regardless of the type of health care professional that delivered the service, adjusted for any payment modifiers as described above. For example, the regional average for a CPT code that represents a chest x-ray was based on all claims for that CPT code, regardless of whether the chest x-ray was read by an emergency department physician or a radiologist. As another example, the regional average for a CPT code that represents an anesthesia service was based on all claims for that CPT code regardless of whether the service was provided by an anesthesiologist or a nurse anesthetist; however, the allowed amount on claims for services delivered by a nurse anesthetist (identified by the presence of the applicable payment modifiers) were first adjusted using the methodology described above to develop an "unmodified" amount.

It should be noted that when examining the top CPT/HCPCS codes as measured by allowed cost, roughly half of all allowed costs for emergency services delivered by non-participating providers were associated with evaluation and management (E&M) codes for emergency department visits (CPT codes 99281-99288) which would typically be billed by a physician specializing in emergency medicine. Some of the other top CPT/HCPCS codes were for either evaluation and management services or specific surgical procedures (e.g., cardiovascular surgery, musculoskeletal surgery), which represent services that would typically be performed by a

limited number of physician specialties with similar skill. Therefore, given Oliver Wyman adjusted for payment modifiers, they do not believe that not being able to vary the regional averages by "category of provider" would significantly affect the calculated financial impact of HB 1714. Further, it is Oliver Wyman's understanding that the proponents of HB 1714 are comfortable with this approach.

There was not a situation under this option where a claim for an emergency service delivered by a non-participating health care professional within the Commonwealth did not have a calculated regional average to apply in evaluating the impact of HB 1714. This is because HB 1714 directs the regional averages to be based on the claims of both participating and non-participating providers, so therefore the non-participating claims being evaluated were also used in developing the regional averages.

Facilities

HB 1714 adds a new requirement to the three currently outlined in statute when establishing the benchmark reimbursement for emergency services delivered by a non-participating facility within the Commonwealth. However, the new requirement, the fair market value of services, is not captured on claims data nor can it be derived from the elements on a claim record. Therefore, there was no way to measure how the allowed amount currently present on the claim record for these services compares to fair market value. As such, the BOI engaged in discussions with the VHHA and other proponents of HB 1714 to come to agreement on a reasonable method for analyzing its potential impact on facility claims.

Initially, the proponents suggested that Oliver Wyman assume that a specified discount from billed charges be used as a proxy for fair market value. While billed charges would typically be captured on a claim record it was not included in the data Oliver Wyman received from the payors due to concerns that providing both billed and allowed charges would reveal information about the proprietary contracts between health insurers and providers. Having access to the allowed charge amounts were critical to the analyses for all policy options being considered. VHHA indicated that because negotiated in-network allowed amounts reflect discounts from standard prices, the fair market value of facility services delivered by non-participating providers within the Commonwealth would in most instances be greater than any of the three amounts outlined in current statute, and therefore the allowed amount for emergency services delivered by non-participating facilities within the Commonwealth could reasonably be expected to be higher relative to the allowed amount currently on the claim record. After further discussion around the type of analyses that could feasibly be performed, VHHA suggested that we model scenarios where the allowed amount currently present on the claim was increased, with the increase ranging from 25% to 45%.

Lookback Provision- Enactment Clause

HB 1714 includes an Enactment Clause, or a Hugo amendment, which is a look-back provision to require a report to determine impact on networks. It is aimed to address health plan concerns that providers will drop out of network. (Lines 224-226). This is a mechanism to track and determine bilateral impact: 1) if providers are dropping out of network and 2) if insurers are dropping providers. Should networks be negatively impacted, the report would provide a basis for the General Assembly to address later if determined necessary. Providers state they will not leave the networks. The Virginia Association of Health Plans (VAHP) does not think look-back provisions will provide meaningful information because it would not detect providers that drop out and re-enter the network.

HB 2544

Under HB 2544, current law would be revised to prohibit non-participating providers delivering emergency services within the Commonwealth from balance billing a covered person, and define the benchmark reimbursement amounts that non-participating facilities and health care professionals would be required to accept as payment in full when providing emergency services in the Commonwealth as the greatest of the following:

1. The average of the contracted commercial rates paid by the payor for the same emergency service in the geographic region, as defined by the Commission, where the emergency service was provided;
2. The amount for the emergency services calculated using the same method the payor generally uses to determine payments for out-of-network services, such as the usual, customary, and reasonable amount; and
3. The amount that would be paid under Medicare for the emergency service.

Current law requires that the payor provide benefits, inclusive of any cost-sharing paid by the covered person, in an amount equal to the greatest of items two and three listed above, and "the amount negotiated with in-network providers for the emergency service, or, if more than one amount is negotiated, the median of these amounts." The first item above essentially replaces the payor's median rate negotiated for the same emergency service among its participating providers statewide, with the payor's average negotiated rate for the same emergency service among its participating providers within the geographic region.

When analyzing the potential impact of HB 2544, the decision of whether or not to replace the allowed amount currently present on claims for emergency services delivered by a nonparticipating facility in the Commonwealth with another amount is contingent upon what the allowed amount currently on the claim record represents. As previously noted, it was assumed that the value currently appearing in the allowed amount field equals the greatest of the three

items listed in current statute. However, which of those three it represents is unknown. Since it was also assumed that the allowed amount currently present on these claims would always be greater than 100% of Medicare, it was assumed that the allowed amount currently on each claim represents either the payor's median rate negotiated for the same emergency service among its participating providers statewide, or the payor's UCR amount. Therefore, theoretically, the following logic should be applied:

1. If it were known that the current allowed amount represents the payor's median negotiated rate for the same emergency service among all of its participating providers, then the allowed amount currently on the claim should be replaced with the payor's regional average negotiated amount for the service if greater than the payor's UCR amount; otherwise the current allowed amount should be replaced with the payor's UCR amount.

2. If it were known that the current allowed amount represents the payor's UCR amount for the same emergency service, then the allowed amount should be replaced with the payor's regional average negotiated amount for the service only if it is greater than the allowed amount currently on the claim.

Since the payor's median rate negotiated for the same emergency service among its participating providers statewide and the payor's UCR amount are unknown, and further it is unknown which of these two amounts is currently present on each claim as the allowed amount, a range was developed for the potential impact of HB 2544 by applying the following logic for the two scenarios described above.

1. In the first scenario, where the current allowed amount is assumed to represent the payor's median negotiated rate among all of its participating providers, the allowed amount on the claim record was always replaced with the calculated regional average negotiated rate for the same service for the payor. If the carrier's UCR amount is greater than the calculated regional average negotiated rate for the payor, then the current allowed amount should be replaced with the UCR amount instead, however this amount is unknown. Therefore, this scenario will tend to slightly understate the expected impact on allowed claims.

2. In the second scenario, where the current allowed amount is assumed to represent the payor's UCR amount, the allowed amount on the claim record was replaced with the calculated regional average negotiated rate for the same service for the payor only if this newly calculated amount was greater than the allowed amount currently present on the claim record.

Given the limitations of the data available, Oliver Wyman believe that the methodology outlined above is the closest approximation for the potential impact of HB 2544 that can be developed. The commercial data provided by payors was used both to develop the regional averages for each payor and for assessing the impact of those regional averages on allowed claims. For consistency with the analyses performed when analyzing the impact of HB 1714, a regional average was developed for each payor at the CPT/HCPCS level, and in the case of inpatient facility claims, at the DRG level. When calculating these regional averages for each payor, only claims for participating providers were used, after limiting the claims to only those for services which met the previously discussed definition of emergency services. As discussed above, prior to determining the regional averages the allowed amounts on all claims containing a CPT/HCPCS code along with a payment modifier were first adjusted to reflect an "unmodified" value. The regional average allowed amounts for each CPT/HCPCS code, region and payor were then developed using the "unmodified" allowed amounts.

Given that the regional averages were required to be determined using only claims for emergency services delivered by participating providers, there were cases where a claim for an emergency service delivered by a non-participating provider within the Commonwealth did not have a regional average to apply when evaluating the impact of HB 2544. Specifically, this occurred when there was a claim for an emergency service delivered by a non-participating health care professional within the Commonwealth, but there was not a corresponding claim for the same CPT/HCPCS or DRG for an emergency service delivered by a participating health care professional, for the same payor and region. This also included claims for anesthesia services for one payor as previously mentioned. In these cases, the impact of HB 2544 could not be directly evaluated and it was assumed that the impact on that claim was equal to the average impact of HB 2544 on all claims for services delivered by non-participating health care professionals for that payor and region, for which a regional average could be developed and the impact of HB 2544 could be directly assessed. Payors were not able to identify which claims were associated with single case agreements, emergency-only participation agreements, or rental network agreements. Therefore, these claims were considered as services delivered by either participating or nonparticipating providers based on how payors populated the network indicator field in the claims data provided for the analyses, which presumably was consistent with how the field was populated in their data warehouse.

Facilities

Additional considerations, beyond those outlined above, applied when evaluating the potential impact that HB 2544 could have on claims for emergency services delivered within an emergency department by a non-participating facility within the Commonwealth. Not all services billed by an emergency department of a hospital utilize CPT/HCPCS codes; some utilize only revenue codes. Oliver Wyman did not feel it was reasonable to develop regional averages based

on revenue codes for these services given the broad definitions used for most revenue codes and therefore the wide variation in the services and corresponding costs that could be provided and billed using the same revenue code.

For example, services billed using revenue codes in the range 250-259 represent charges for medication produced, manufactured, packaged dispensed, and distributed under the direction of a licensed pharmacist and do not require CPT/HCPCS coding. Further, the value of the drug being billed for when using these codes can range from a few dollars to several hundred dollars. As such, calculating and applying a regional average for these services would result in significant overstatement for certain drugs and significant understatement for others. For those claims for emergency services billed by a facility in an emergency department setting that do not contain a CPT/HCPCS code, the methodology presented above was not applied. Instead, the potential impact of HB 2544 on claims for emergency services delivered within an emergency department by a non-participating facility within the Commonwealth, was estimated as being equal to the average impact on those claims where a CPT/HCPCS was present and for which a regional average could be developed, for that payor and region. Oliver Wyman noted that roughly 88% of allowed costs for emergency services delivered within an emergency department by a non-participating facility within the Commonwealth contained a CPT/HCPCS code, while the remaining 12% were for claims that do not utilize CPT/HCPCS codes.

Additional Option: Reimbursement of 200 Percent of Medicare

Under this policy option, current law would be revised to prohibit non-participating providers delivering emergency services within the Commonwealth from balance billing a member, and define the benchmark reimbursement amount that non-participating facilities and health care professionals would be required to accept as payment in full when providing emergency services in the Commonwealth. The benchmark reimbursement would be defined as two times the amount that Medicare would allow for the same service. As such, when evaluating the potential impact of this proposal, the allowed amount currently present on all claims for emergency services delivered by non-participating providers within the Commonwealth were replaced with an estimate of two times the amount that Medicare would allow, regardless of the allowed amount currently present on the claim.

Health Care Professionals

In evaluating the potential impact of this policy option on emergency services delivered by nonparticipating health care professionals within the Commonwealth, an estimate of the amount Medicare would have allowed in the Commonwealth in 2017 was determined. Specifically, in developing these estimates the applicable 2017 values/factors were used for items including, but not limited to, the conversion factor applicable to the RBRVS fee schedule, the geographic

practice cost index factors, the conversion rate to be used for anesthesia services, base and frailty units for anesthesia services, the relative value units (RVUs) for the work, practice, and medical malpractice components, and CPT/HCPCS payment modifier applicability and adjustment factors. Given that the emergency services that are the subject of the analyses were delivered in a facility setting, Oliver Wyman utilized the practice expense RVUs applicable to a facility setting. Finally, they reviewed the anesthesia data, excluding data for the payor that was unable to accurately provide units, to determine the appropriate point at which to assume the units field on claim records represents the number of minutes billed for anesthesia services vs. when it represents the number of units billed for anesthesia services.

In evaluating the potential impact of this policy option on emergency services delivered by nonparticipating facilities within the Commonwealth, an estimate of the Medicare allowed amount was developed based on the amount Medicare would have allowed in the Commonwealth in 2017, based on the information that was available on the claim records. For services delivered in an emergency department setting, hierarchical logic under the Outpatient Prospective Payment System (OPPS) was applied to all claim lines for a given individual where the place of service field was populated with a value of 23 and all claim lines reflected the same date of service, in order to assign an ambulatory payment classification (APC) to the bundled claim. The Medicare allowed amount was then estimated for the assigned APC, and multiplied times two to determine the revised allowed amount for the entire encounter (i.e., for all claims lines associated with the APC collectively). Claim lines for services that are not grouped into an APC (e.g., CPT/HCPCS codes with a status indicator of A) were assigned an allowed amount equal to two times the 2017 Medicare allowed amount under OPPS for that CPT/HCPCS code. For emergency services delivered by a nonparticipating facility, in an inpatient facility setting, the revised allowed amount could not be estimated. This is due to the fact that under the Inpatient Prospective Payment System, the Medicare allowed amount for a given DRG varies by hospital. The appropriate information needed to determine the Medicare allowed amount for these inpatient facility claims was not included on the claims information provided by the carriers (i.e., the rendering inpatient facility was not identified). Therefore, emergency services delivered in an inpatient facility setting by non-participating facilities within the Commonwealth could not be directly modeled under this policy option. Instead, the impact (i.e., percent increase or decrease) on these inpatient facility claims for emergency services was assumed to be equal to the average increase/decrease that resulted from the modeling for emergency services delivered within an emergency department for non-participating facilities, for the same payor within that same region. Finally, Oliver Wyman note that Medicare does not allow for a separate payment to be made for services delivered within an emergency department under OPPS when an individual is ultimately admitted from the emergency department. However, when evaluating this policy option, if an individual was admitted to the hospital from the emergency department it was assumed that a payment would still be made for the facility services provided while in the emergency department, and that the amount of the payment would be equal to two times the

amount Medicare would have allowed had the individual instead been discharged from the emergency department.

Results

In this section, Oliver Wyman presents the results of their analyses of the out-of-network emergency services surprise billing analyses provided to the Commonwealth of Virginia by Oliver Wyman, when employing the methodology described in the prior section to the data provided by the payors. The actuarial consultant team modeled the impact on allowed claims under each of the three policy options studied, and present the results by the following categories:

1. The impact on allowed claims for emergency services that were delivered by non-participating health care professionals within the Commonwealth, in total, and separately for the following six categories of service:
    a. Emergency department visits[10]
    b. All other evaluation and management (E&M) services[11]
    c. Surgical procedures[12]
    d. Anesthesia services[13]
    e. Physical medicine
    f. All other emergency services[14]
2. The impact on allowed claims for emergency services that were delivered by nonparticipating facilities within the Commonwealth
3. The impact on allowed claims for all medical and prescription drug services covered under the comprehensive health insurance policies.

The impact on paid claims cannot be modeled without re-adjudicating each claim based on the underlying benefits, which represents an enormous amount of work and was outside the scope of the analyses. However, Oliver Wyman expects that the impact on paid claims, and therefore the impact on premiums, would be similar to the impact on allowed claims described in item three above.

[10] Defined as claims containing CPT codes in the range 99281-99288
[11] Defined as claims containing CPT codes in the range 99201-99499, excluding 99281-99288
[12] Defined as claims containing CPT codes in the range 10021-69990
[13] Defined as claims containing CPT codes in the range 00100-01999
[14] Defined as claims containing CPT codes in the range 90281-99199

HB 1714

The following table presents the modeled impact on allowed claims for emergency services that were delivered by non-participating health care professionals and facilities within the Commonwealth, assuming HB 1714 were enacted. Oliver Wyman presented the overall average for each category of service, along with the impact on the region with the lowest impact and the region with the highest impact for that category of service, for services provided by health care professionals. While the region that represents the one with the lowest/highest impact for each category of service is the same for all services that fall into that row, a different region may represent the lowest/highest impact for each row. When estimating the overall impact on all allowed claims for emergency services that were delivered by non-participating providers within the Commonwealth (the last set of rows in the table below) the column for the lowest regional impact utilizes the scenario where fair market value for facility services is 25% higher than the allowed amount currently present on the claim record and the column for the highest regional impact utilizes the scenario where fair market value for facility services is 45% higher than the allowed amount currently present on the claim record. For the total rows, the lowest/highest impacts were based on calculating the impact across all services for each region, and selecting the region with the lowest/highest overall impact.

			HB 1714 Average Impact on Allowed Costs		
Provider Type	Category of Service	Percent of Claims[1]	Overall	Lowest Region	Highest Region
Professional	Emergency Department Visits	17.0%	13%	1%	75%
Professional	Other E&M Services	7.1%	19%	6%	23%
Professional	Surgical Procedures	7.0%	40%	11%	55%
Professional	Anesthesia Services	3.3%	120%	42%	333%
Professional	Physical Medicine	2.3%	24%	5%	32%
Professional	All Other Emergency Services	1.4%	21%	13%	27%
Professional		38.1%	30%	6%	45%
Facility	FMV (25% Incr. to Allowed)	61.9%	25%	25%	25%
Facility	FMV (45% Incr. to Allowed)	61.9%	45%	45%	45%
Total	FMV (25% Incr. to Allowed)	100.0%	27%	21%	
Total	FMV (45% Incr. to Allowed)	100.0%	39%		45%

[1] Represents the percent of all claims for emergency services delivered by non-participating providers within the Commonwealth

The following table presents the modeled impact on allowed claims for all medical and prescription drug services covered under comprehensive health insurance policies, assuming HB 1714 were to be enacted. Based on the results, enactment of HB 1714 could be expected to

increase overall allowed costs by approximately +0.1% on average, varying by region from +0.0% to +0.3%.

			HB 1714 Average Impact on Allowed Costs			
			FMV = +25%		FMV = +45%	
Provider Type	Category of Service	Percent of Claims	Overall	Lowest Region	Overall	Highest Region
Professional	Non-Par Emergency[1]	0.1%	29.6%	6.0%	29.6%	44.5%
Facility	Non-Par Emergency[1]	0.2%	25.0%	25.0%	45.0%	45.0%
All	All Other	99.7%	0.0%	0.0%	0.0%	0.0%
Total		**100.0%**	**0.1%**	**0.0%**	**0.1%**	**0.3%**

[1] Represents all claims for emergency services delivered by non-participating providers within the Commonwealth

HB 2544

The following table presents the modeled impact on allowed claims for emergency services that were delivered by non-participating health care professionals and facilities within the Commonwealth, assuming HB 2544 were to be enacted. Oliver Wyman presented the overall average for each category of services, along with the impact on the region with the lowest impact and the region with the highest impact for that category of service, for services provided by health care professionals. While the region that represents the one with the lowest/highest impact for each category of service is the same for all services that fall into that row, a different region may represent the lowest/highest impact for each row. For the total row, the lowest/highest impact was based on calculating the impact across all services for each region, and selecting the region with the lowest/highest overall impact. Oliver Wyman presented the results for the two scenarios that were modeled. The first table below presents the results when making the assumption that the current allowed amount represents the payor's median negotiated rate with participating providers for the same emergency service among all of its participating providers. The second table below presents the results when making the assumption that the current allowed amount represents the payor's UCR amount for the same emergency service.

Current Allowed Equals Median Negotiated Rate			HB 2544 Average Impact on Allowed Costs		
Provider Type	Category of Service	Percent of Claims[1]	Overall	Lowest Region	Highest Region
Professional	Emergency Department Visits	17.0%	-45.3%	-66.0%	21.6%
Professional	Other E&M Services	7.1%	-7.5%	-37.3%	8.4%
Professional	Surgical Procedures	7.0%	-33.4%	-40.8%	-3.7%
Professional	Anesthesia Services	3.3%	-24.1%	-52.7%	49.3%
Professional	Physical Medicine	2.3%	-20.1%	-38.8%	16.8%
Professional	All Other Emergency Services	1.4%	-30.3%	-47.2%	-2.7%
Professional	All	38.1%	-32.1%	-52.8%	-14.6%
Facility	All	61.9%	25.5%	-20.6%	177.0%
Total	All	100.0%	3.6%	-35.6%	108.0%

Current Allowed Equals UCR			HB 2544 Average Impact on Allowed Costs		
Provider Type	Category of Service	Percent of Claims[1]	Overall	Lowest Region	Highest Region
Professional	Emergency Department Visits	17.0%	7.0%	0.9%	42.3%
Professional	Other E&M Services	7.1%	16.9%	7.7%	23.0%
Professional	Surgical Procedures	7.0%	13.2%	8.9%	24.3%
Professional	Anesthesia Services	3.3%	29.8%	8.3%	78.0%
Professional	Physical Medicine	2.3%	15.1%	3.4%	33.8%
Professional	All Other Emergency Services	1.4%	12.2%	8.7%	21.6%
Professional	All	38.1%	12.7%	4.7%	18.9%
Facility	All	61.9%	54.3%	15.1%	187.3%
Total	All	100.0%	38.5%	12.6%	126.6%

[1] Represents the percent of all claims for emergency services delivered by non-participating providers within the Commonwealth

The following observations can be made from the tables above:

- The modeled overall average impact of HB 2544 on services delivered by nonparticipating providers varies widely based on whether or not it is assumed that the allowed amount currently present on the claim record represents the payor's median negotiated rate with participating providers or whether it represents the payor's UCR amount. While it is unknown which of these values is currently represented on the claim, given it is common for payors to set their UCR at levels close to the 75th or 80th percentile, Oliver Wyman believes the more likely of the two is that the current allowed amount represents a payor's UCR amount.

- There is a large difference between the impact on allowed claims for these services for the region with the lowest impact and the region with the highest impact. This regional

variation is much more significant for facility claims than it is for claims for services of a health care professional.

The following tables present the modeled impact on allowed claims for all medical and prescription drug services covered under comprehensive health insurance policies, assuming HB 2544 were to be enacted. Again, Oliver Wyman presented the results for the two scenarios that they modeled. Based on the results, enactment of HB 2544 could be expected to increase overall allowed costs by approximately +0.0% to +0.1% on average, ranging by scenario and region from -0.2% to +0.4%.

Current Allowed Equals Median Negotiated Rate			HB 2544 Average Impact on Allowed Costs		
Provider Type	Category of Service	Percent of Claims	Overall	Lowest Region	Highest Region
Professional	Non-Par Emergency[1]	0.1%	-32.1%	-52.8%	-14.6%
Facility	Non-Par Emergency[1]	0.2%	25.5%	-20.6%	177.0%
All	All Other	99.7%	0.0%	0.0%	0.0%
Total		**100.0%**	**0.0%**	**-0.2%**	**0.3%**

Current Allowed Equals UCR			HB 2544 Average Impact on Allowed Costs		
Provider Type	Category of Service	Percent of Claims	Overall	Lowest Region	Highest Region
Professional	Non-Par Emergency[1]	0.1%	12.7%	4.7%	18.9%
Facility	Non-Par Emergency[1]	0.2%	54.3%	15.1%	187.3%
All	All Other	99.7%	0.0%	0.0%	0.0%
Total		**100.0%**	**0.1%**	**0.0%**	**0.4%**

[1] Represents all claims for emergency services delivered by non-participating providers within the Commonwealth

200 Percent of Medicare Option

The following table presents the modeled impact on allowed claims for emergency services that were delivered by non-participating health care professionals and facilities within the Commonwealth, assuming this proposal was enacted. They presented the overall average for each category of services, along with the impact on the region with the lowest impact and the region with the highest impact for that category of service, for services provided by health care professionals. While the region that represents the one with the lowest/highest impact for each category of service is the same for all services that fall into that row, a different region may represent the lowest/highest impact for each row. For the total row, the lowest/highest impact was based on calculating the impact across all services for each region, and selecting the region with the lowest/highest overall impact.

Provider Type	Category of Service	Percent of Claims[1]	200% OF Medicare Average Impact on Allowed Costs		
			Overall	Lowest Region	Highest Region
Professional	Emergency Department Visits	17.0%	-42.5%	-62.4%	11.3%
Professional	Other E&M Services	7.1%	45.3%	7.7%	73.8%
Professional	Surgical Procedures	7.0%	5.0%	-3.0%	73.3%
Professional	Anesthesia Services	3.3%	-45.9%	-60.6%	8.4%
Professional	Physical Medicine	2.3%	9.7%	7.2%	45.5%
Professional	All Other Emergency Services	1.4%	30.9%	3.5%	99.8%
Professional	All	38.1%	-11.9%	-39.4%	32.1%
Facility	All	61.9%	-24.4%	-69.9%	115.8%
Total	All	100.0%	-19.7%	-56.9%	67.2%

[1] Represents the percent of all claims for emergency services delivered by non-participating providers within the Commonwealth

The following observations can be made from the table above:

- The impact of reimbursing emergency services delivered by non-participating providers within the Commonwealth at 200% of Medicare is expected to lead to a change in allowed costs of -11.9% for services delivered by health care professionals and -24.4% for services delivered by facilities.
- Within the set of services delivered by health care professionals, professionals providing services for emergency department visits and anesthesia services could be expected to observe significant reductions in overall allowed cost (-42.5% and -45.9% reductions, respectively), while professionals providing other categories of emergency services could be expected to observe an increase in allowed costs.
- This policy option could result in a significantly different impact by region, with the region modeled to experience the lowest overall impact potentially experiencing an average change in allowed costs of -56.9% and the region modeled to experience the highest overall impact potentially experiencing an average change in allowed costs of +67.2%. The variation by region is much larger for facility services than for services of a health care professional.

The following table presents the modeled impact on allowed claims for all medical and prescription drug services covered under comprehensive health insurance policies, assuming this proposal was enacted. Based on the results, enactment of this proposal could be expected to decrease overall allowed costs by approximately -0.1% on average, ranging by region from -0.4% to +0.2%.

			200% of Medicare Average Impact on Allowed Costs		
Provider Type	Category of Service	Percent of Claims	Overall	Lowest Region	Highest Region
Professional	Non-Par Emergency[1]	0.1%	-11.9%	-39.4%	32.1%
Facility	Non-Par Emergency[1]	0.2%	-24.4%	-69.9%	115.8%
All	All Other	99.7%	0.0%	0.0%	0.0%
Total		**100.0%**	**-0.1%**	**-0.4%**	**0.2%**

[1] Represents all claims for emergency services delivered by non-participating providers within the Commonwealth

The above results are based on the combined fully and self-insured data which was received from the payors. Oliver Wyman also reviewed the impact when utilizing only the fully-insured data. There was no change to the regional averages used in the analyses as their understanding is that these values should be based on the combined data. The table below presents the modeled impact on allowed claims for emergency services that were delivered by nonparticipating health care professionals and facilities within the Commonwealth, under each of the policy options and scenarios modeled, when limited to only fully insured data. When comparing the impact by funding type (i.e., fully-insured only vs. combined fully and self- insured), there was minimal difference in the percentage impact for the professional provider type. However, there was a significant decrease in the impact for the facility provider type which ranged between 14% and 39%, excluding HB 1714 where the facility impact was set to be the same.

		Average Impact on Allowed Costs (Fully-Insured Only)				
Provider Type	% of Claims[1]	HB 1714 FMV=+25%	HB 1714 FMV=+45%	HB 2544 Median	HB 2544 UCR	200% Medicare
Professional - Total	37.9%	29.7%	29.7%	-31.3%	12.3%	-11.9%
Facility - Total	62.1%	25.0%	45.0%	7.1%	40.0%	-63.3%
Total	**100.0%**	**26.8%**	**39.2%**	**-7.5%**	**29.5%**	**-43.9%**

[1] Represents the percent of all claims for emergency services delivered by non-participating providers within the Commonwealth

The table below presents the modeled impact on allowed claims across all medical and prescription drug services, when limited to only fully insured data. The difference in the total impact between funding types ranges from -0.12% (200% of Medicare) to +0.05% (HB 1714, FMV = +45%). This difference is a result of a change in the impact for the facility provider type as discussed in the first table as well as a slightly larger percentage of claims for emergency services delivered by non-participating providers within the Commonwealth when using fully-insured data only.

			Average Impact on Allowed Costs (Fully-Insured Only)				
Provider Type	Category of Svc.	% of Claims[1]	HB 1714 FMV=+25%	HB 1714 FMV=+45%	HB 2544 Median	HB 2544 UCR	200% Medicare
Professional	Non-Par Emergency[1]	0.1%	29.7%	29.7%	-31.3%	12.3%	-11.9%
Facility	Non-Par Emergency[1]	0.2%	25.0%	45.0%	7.1%	40.0%	-63.3%
All	All Other	99.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Total		**100.0%**	**0.1%**	**0.2%**	**0.0%**	**0.1%**	**-0.2%**

[1]Represents all claims for emergency services delivered by non-participating providers within the Commonwealth

Network Participation

The information that could be provided to help the BOI in assessing the potential impact on provider networks is very limited given the information available (e.g., information is not available at the network or provider level, it is not known what the UCR amount is that would apply to a claim for a participating provider if that provider had instead been non-participating, etc.). It is expected that what is determined as the payment standard under the three policy options studied would have a significantly lesser impact on network participation decisions made by facilities than it would on network participation decisions made by health care professionals.

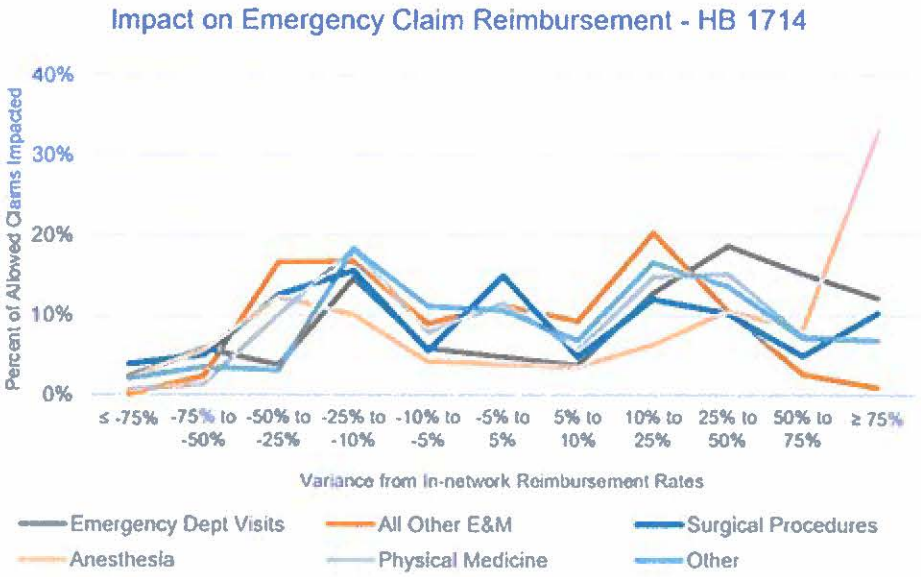
In many cases, individuals can choose the facility at which they seek services for non-life threatening emergency services. This is not necessarily the case for emergency services delivered by health care professionals they may encounter while being treated at a participating facility. Additionally, a facility will be less likely to terminate its network participation agreement as a result of the policy options studied in this report as the impact of any potential increase in reimbursement for emergency services may be very small relative to the adverse financial impact that could result from becoming a non-participating provider for all other facility services. Therefore, Oliver Wyman has limited the analysis in this section to only services provided by health care professionals.

To assist the BOI and other key stakeholders in assessing the potential impact that these policy options could have on network participation, Oliver Wyman conducted a high-level analysis to compare the allowed charges on claims for emergency services delivered by participating providers with the reimbursement they could instead receive as a non-participating provider, under each of the three policy options. Oliver Wyman notes that the applicable benchmark reimbursement amounts under HB 1714 and HB 2544 are the greatest of several items listed in the draft Bills, however, it is not possible to discern from adjudicated claims for participating providers what the values for a payor's median amount negotiated with in-network providers or UCR amount might be. Therefore, the analyses were limited to a comparison of the allowed amounts present on claims for emergency services delivered by participating providers and the regional averages applicable to these two policy options. For the third option where the

benchmark reimbursement amount would be equal to 200% of Medicare, the allowed amounts present on the claims were compared to an estimate of reimbursement equal to 200% of the 2017 Medicare allowed amount. For purposes of these analyses, emergency services were assigned one of six categories based on the CPT/HCPCS code recorded on each claim line, consistent with the categories used to present the results in the prior section. For the claims within each category that represent emergency services delivered by participating providers, the allowed amount recorded on the claim line was compared to either the applicable regional average (for HB 1714 and HB 2544) or 200% of Medicare. The charts below present the results for each of the three policy options studied. The x-axis in each graph represents the expected impact on allowed claims, and the y-axis shows the percent of total allowed claims for that type of service that would be expected to have the stated impact on reimbursement.

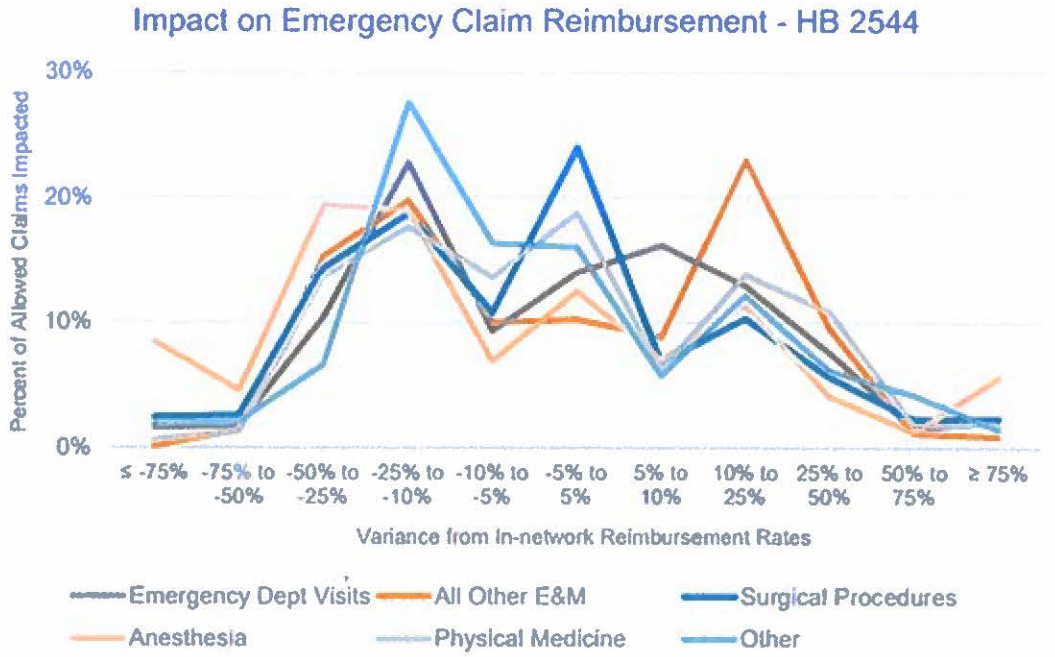
HB 1714

As previously discussed, under HB 1714, the regional average for each CPT/HCPCS code is defined as the straight average of the median allowed amounts for each payor offering coverage within the region. The nature of using the straight average, as opposed to a weighted average, of the medians results in a wider spread of changes; across all six categories of service, only about 22% of claim dollars are associated with claims where the current allowed amount is within plus-or-minus 10% of the calculated regional average of the medians. The chart shows the distribution of the difference between the allowed amounts currently on claims and the applicable calculated regional average of the medians. For example, over 30% of claims (as measured by allowed costs) for emergency anesthesia services delivered by participating providers would be expected to realize an increase in the allowed amount of more than 75%, and roughly 50% of claims (as measured by allowed costs) would be expected to realize an increase in the allowed amount of more than 25%. Likewise, roughly 35% of claims (as measured by allowed costs) for emergency department visits delivered by participating providers would be expected to realize an increase in the allowed amount of more than 25% over current levels.



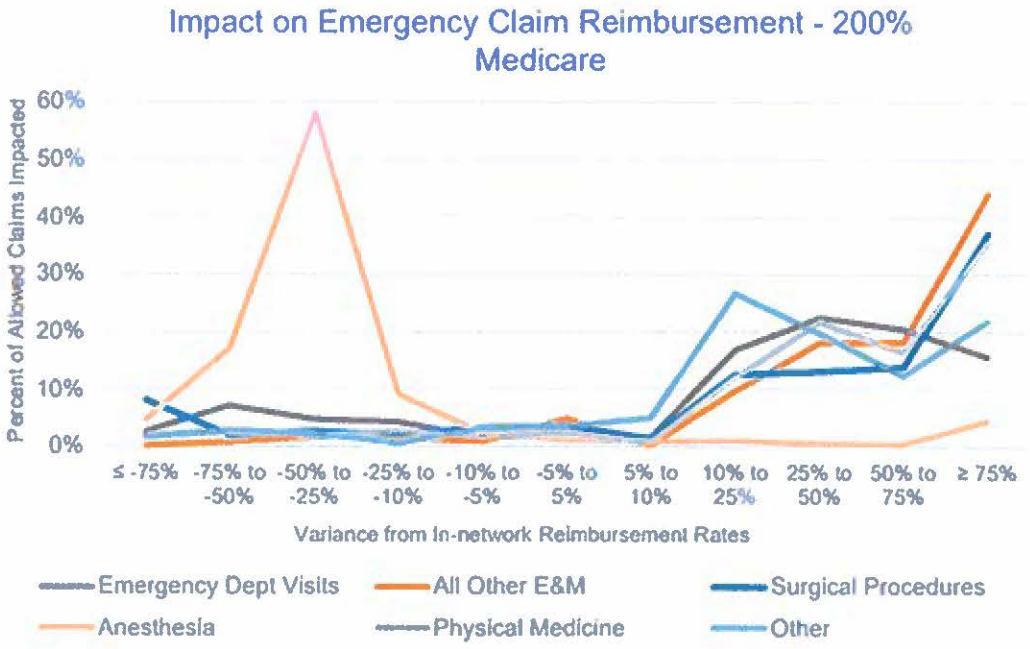
HB 2544

Under HB 2544, the regional average for a given CPT/HCPCS code is representative of the average allowed amount per service for emergency services delivered by a participating provider, for each payor and region. Due to the calculated regional average representing an average of the carrier's own contracted rates with participating providers in the region, the impact tends to be fairly uniform with the impacts more concentrated around 0% than for HB 1714, with about half of the emergency services delivered by a participating provider being associated with claims where the provider would experience a decrease in reimbursement and about half being associated with an increase, should the provider cease to be a participating provider. Across all six categories of service, the current allowed amount for emergency services delivered by participating providers for approximately 36% of claims (as measured by allowed costs) is within plus-or-minus 10% of the calculated regional average for the carrier.



Additional Proposal – 200 Percent of Medicare

Under this proposal, in which the amount that a non-participating provider would be required to accept as payment in full would be equal to 200% of Medicare, most participating providers would be expected to experience an increase in their reimbursement relative to current levels, should the provider cease to be a participating provider. In other words, the current contracted rates with participating providers are generally below 200% of Medicare for most categories of service. The exception is anesthesiologists, who are currently being reimbursed more than 200% of Medicare, and would experience a decrease in reimbursement if they were to instead be reimbursed at 200% of Medicare. Across all six categories of service, the current allowed amount for non-participating providers on only approximately 7% of claims (as measured by allowed costs) is within plus-or-minus 10% of 200% of Medicare.


Impact on Emergency Claim Reimbursement - 200% Medicare
Percent of Allowed Claims Impacted
60%
50%
40%
30%
20%
10%
0%
≤ -75%
-75% to -50%
-50% to -25%
-25% to -10%
-10% to -5%
-5% to 5%
5% to 10%
10% to 25%
25% to 50%
50% to 75%
≥ 75%
Variance from In-network Reimbursement Rates
Emergency Dept Visits
All Other E&M
Surgical Procedures
Anesthesia
Physical Medicine
Other

Actuarial Analyses of Policy Options to Address Surprise Billings for Out-of-Network Emergency Services in Virginia for State Employees - *Supplement to the Oliver Wyman Report*

As a supplement to the out-of-network emergency services surprise billing analysis provided to the Commonwealth of Virginia by Oliver Wyman, Aon, actuary for the Department of Human Resource Management, estimated the cost impact to the state employee health plan for the three options as outlined in their report. This supplemental document is not considered a stand-alone document and should only be read in conjunction with Oliver Wyman's report.

Data Sources

Aon requested 2017 claims data from Anthem and Aetna for the state employee health plan in the same format and with the same content as Oliver Wyman's data request to all the carriers in the Commonwealth of Virginia. Following the same approach as Oliver Wyman, they pared down the files to include emergency room claims (coded with a place of service code of "23") and inpatient claims that can be tied to an emergency room claim on the same date. As noted in Oliver Wyman's report, some claims may be included that are not true emergency claims per the statutory definition.

Description	Allowed Dollars	Paid Dollars
Aggregate State Health Plan Claims Data (Anthem & Aetna)	$1,287,781,165	$1,172,221,935
Claims for Services Identified with Place of Service 21 or 23	$369,858,790	$352,436,164
Emergency Services	$28,685,707	$27,837,299
Emergency Services Delivered by Non-Participating Providers	$795,957	$722,659
Emergency Services Delivered by Non-Participating Providers within the Commonwealth	$422,161	$391,991

The state plan's out-of-network emergency services in the Commonwealth account for only 0.03% of total claims in 2017 compared to the aggregate carrier data that Oliver Wyman collected showing 0.3%.

The projected FY2021 total plan paid self-insured claims based on July 2019 enrollment is $1.4B. Oliver Wyman provided Aon with the following data:

- Averages of the carrier regional medians by CPT code and region for professional services, including adjustments to be applied for payment modifiers, for use under House Bill 1714;
- Carrier regional averages by CPT code and region for professional services, separately for Aetna and Anthem, including adjustments to be applied for payment modifiers, for use under House Bill 2544;
- Carrier regional averages by CPT code and region for institutional services, separately for Aetna and Anthem, including adjustments to be applied for payment modifiers, for use under House Bill 2544;
- Carrier regional averages by DRG code and region for inpatient institutional services, separately for Aetna and Anthem, for use under House Bill 2544; and,

- Zip code to region mapping that originally was provided to them by the BOI

Aon utilized the facility setting claim amounts from the 2017 Medicare Physician Fee Schedule associated with the Commonwealth of Virginia Carrier Number and Locality Code to map each CPT and modifier code. We also applied the payment modifier codes that Oliver Wyman provided by CPT for HB 1714 and HB 2544.

Data Limitations

The data received from Anthem and Aetna was matched with the Oliver Wyman supplied data for House Bills 1714 and 2544 and the 2017 Medicare Physician Fee Schedule. Not all CPT/DRG codes in Anthem's and Aetna's data could be mapped. The chart below shows the percentage of claim dollars that were excluded from the analysis due to unmatched codes.

	HB 1714	HB 2544	200% Medicare
CPT/DRG Not Matching	0.1%	3.0%	0.5%

Oliver Wyman may have not experienced the same level of unmatched data in their analysis because the state employee health plan is self-insured and Oliver Wyman did not receive self-insured claim data from all the carriers.

Claim records reflecting allowed claims of $0 were excluded from the analysis.

Claim records with a missing provider zip code were assumed to be for services provided outside the Commonwealth of Virginia.

For the impact on non-participating Virginia facilities for House Bill 1714, Aon utilized the 25% and 45% cost increases that Oliver Wyman presented in their report for facility charges as recommended by the VHHA.

For the impact on non-participating Virginia facilities for House Bill 2544 and the 200% of Medicare option, Aon only valued the professional claims and assumed that the impact for facility claims will be approximately the same. The 2017 non-participating emergency services facility claims represent a very small portion of total claims and applying the data tables to those claims produces results that are not reasonable.

Estimated State Employee Plan Cost Impact

Given the low volume of emergency services delivered out-of-network for the state employee health plan, the overall impact for each of the proposed options is relatively low. The chart below shows the fiscal impact to the projected FY2021 plan paid claims under the proposed payment options. The impacts were developed by applying the resulting percentage impact based on 2017 plan paid claims to the projected FY2021 plan paid cost before any reimbursement changes to out-of-network providers. While the actual volume of out-of-network emergency services may vary from year-to-year, we do not expect a big variation in the relative percentage impact to plan paid costs.

	Cost Impact For Changing Payment to Out-of-Network Providers		
	HB 1714	HB 2544	200% Medicare
FY2021 Plan Paid Cost Impact	$150K - $250K	$98K - $117K	$0.4M - $0.7M

The impact for the 200% Medicare reimbursement option determined by Aon for the state health plan may differ from the impact that Oliver Wyman calculated for the Commonwealth of Virginia for the following reasons:

- The state's self-insured health plans are administered by only two carriers while Oliver Wyman's analysis includes self-insured and fully-insured claims data from seven carriers across the Commonwealth
- The distribution of services by carrier, provider, and region may differ
- Facility claims represent a larger portion of total out-of-network emergency services than professional claims. Oliver Wyman had sufficient data to value the cost impact to facility claims. The facility data that Aon received for the state health plan represented a limited number of facilities, producing results that were not deemed reasonable. As a result, Aon set the impact for facilities to be equal to the impact for professional claims.

The impact to plan costs goes beyond the change in reimbursement for out-of-network emergency services. There is also a cost associated with participating providers seeking greater reimbursement by either leaving the network or negotiating better contracts. To evaluate the likelihood of each provider seeking better reimbursement, Aon needs data that includes all emergency and non-emergency claim detail by provider over a multiple year period. There was not ample time to collect and analyze this level of claim detail. Using the data that Aon does have, they valued each in-network professional emergency service claim record at the greater of the current amount and the amount under each of the proposed options. Following this approach has limitations such as the following:

- The portion of the emergency services included in the data that are associated with providers that also perform non-emergency services is unknown. Some providers may

continue to have a financial incentive to stay in-network when considering their contracts for all services.

- While it is unlikely for a facility to leave the network seeking greater reimbursement for emergency room claims, a facility may use any new out-of-network provider payment requirements for emergency services in their contract negotiations.
- Some providers may negotiate a reimbursement above what is paid to out-of-network providers for emergency services under the proposed options.

Considering the limitations of the data as outlined above, Aon estimates the FY2021 plan paid claims cost impact to the network participation/contracts to be as follows:

	Cost Impact to Network Participation/Contracts		
	HB 1714	HB 2544	200% Medicare
FY2021 Plan Paid Cost Impact	$3.5M - $7.0M	$0.3M - $1.5M	$4.6M - $9.3M

The total FY2021 cost impact under the three options is not expected to exceed $10.0M, which represents less than a 1% cost increase in total expected FY2021 plan paid claims. The potential for long-term plan cost impacts still exists. For example, other provider groups, such as anesthesiologists, may use the change to the reimbursements for out-of-network emergency services as leverage in their contract negotiations. This potential cost impact is beyond the scope of this analysis.

Virginia Considerations

Payment Standard

The Virginia College of Emergency Physicians supported using APCD as a payment standard, because it is publicly available information and provides transparency. Concerns were expressed that Virginia has lower rates than other states in the existing climate. Further, providers indicate that the federal EMTALA law undermines negotiating power of emergency physicians due to the obligation to provide emergency service regardless of insurance status. Payment standards must take into account the cost of running the Emergency Department and be transparent; otherwise, it is unworkable.

The commercially reasonable rate or Fair Market Value would not necessarily replace, but be added to the greater than 3 payment rule stated in Virginia Code as a fourth option. (California uses the greater of 2 values.) NGA suggested using a percent of Medicare to set benchmark rate would support the goals of transparency and predictability. It was stated that the 3-payment rule

in-network rate is higher of the 3 because providers lack negotiating power. With a Medicare standard, it becomes a floor.

In addition to the issues contemplated in the three proposals bills above, there are several other issues discussed by the group.

Regional Average for Commercial Payments
The 2017 data incudes charges for balance billing, which skews towards the highest level of charges. The Office of the Secretary of Health and Human Resources suggested that for determining a payment standard, replace "average" with "median". The Virginia College of Emergency Physicians stated they would consider this.

State Employee Plan Impact
One concern raised in the Workgroup was the potential impact of balance billing provisions (including prohibiting balance billing) on network access including the Virginia State Employee Health Plan. The Code of Virginia in § 2.2-2818.2 "Application of mandate to the state employee health insurance plan", states that insurance mandates for accident and health insurance policies also apply to health coverage offered to state employees. The Virginia Attorney General provided an informal opinion confirming that the state employee plans would be subject to balance billing provisions under the Insurance Mandate section of the Code. Further, the Virginia Department of Human Resource Management (DHRM) indicated that currently the state does not pay more for balance billing, only in very limited circumstances. The above analysis outlines how each policy option could impact network participation.

Self-Insured Opt-In
The group acknowledged that balance billing protections would not apply to self-insured plans. However in order to maximize the impact of proposed protections, some states have provided for an opt-in provision for self-insured plans. The payors supported this idea and the providers said they would be willing to consider it.

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Emergency vs. Non-Emergency Settings
Item 281F of the 2019 Appropriation Act requires consideration of emergency settings. Workgroup discussions were generally focused on emergency settings. The group conversation focused on provisions to impact emergency settings.

Other Considerations

- The Virginia APCD may have some limitations in adequacy of data for the purposes of establishing a payment standard. It comprises all fully insured claims and 40-45% of

commercial market (individual, small group, and non-ERISA market). It may include ERISA reporting, but that is not mandated or guaranteed.

- The group addressed the frequency of individuals taken to hospitals out of network.
- Anthem reports having 25% of the fully insured markets.
- Several group members expressed belief that it is common for individuals to be taken to an out of network hospital.
- Virginia Health Information (VHI) methodology for producing the pricing report utilizes the median, not the average, of commercially allowed amounts for both in and out of network. There are also other limitations to VHI data for the purposes of this report. They remove the top and bottom 5% of allowed amounts, the amounts calculated for the pricing report do not take into consideration the impact of payment modifiers, and in some cases present case rates rather than rates for a single procedure.
- While 13 states have passed comprehensive balance billing laws, implementation has been too recent to see measurable impact on provider networks. The California law passed in 2017, and early indicators suggest a 16% increase in in-network providers.
- The broader issue of network adequacy has not been examined in any of the bills.

Summary and Conclusion

The Virginia Surprise Billing Workgroup held robust discussions of national approaches to balance billing and how different state actions could inform Virginia's policy development. In its deliberations, the group consulted with national experts and studied the potential options explored in other states. While conversations remained focused on emergency settings, hold harmless provisions, provider reimbursement, and potential impact on state employee plans, general agreement was reached only on the common goal of protecting consumers from having to pay balance bills.

Oliver Wyman, actuarial consultant for the Bureau of Insurance evaluated the impact of HB 1714, HB 2544, and an additional proposal for reimbursement rate of 200%. For each scenario, Oliver Wyman modeled the impact on allowed claims under each of the three policy options studied, and represented the results by the following categories:

1. The impact on allowed claims for emergency services that were delivered by nonparticipating **health care professionals** within the Commonwealth, in total, and separately for the following six categories of service, emergency department visits[15], other evaluation and management services[16], surgical procedures[17], anesthesia services[18], physical medicine, and all other emergency services.[19]

[15] Defined as claims containing CPT codes in the range 99281-99288
[16] Defined as claims containing CPT codes in the range 99201-99499, excluding 99281-99288
[17] Defined as claims containing CPT codes in the range 10021-69990
[18] Defined as claims containing CPT codes in the range 00100-01999
[19] Defined as claims containing CPT codes in the range 90281-99199

2. The impact on allowed claims for emergency services that were delivered by **nonparticipating facilities** within the Commonwealth.

3. The impact on allowed claims for **all medical and prescription drug services covered under the comprehensive health insurance policies.**

Under the provisions of HB 1714, Oliver Wyman found that the impact on overall costs for emergency services delivered by out-of-network professionals would be an increase of 30% from current allowed costs, while services delivered in facilities could see an increase of 25-45%. However, for all medical services, the overall impact of HB 1714 was expected to be an increase of 0.1-0.3%.

Under the provision of HB 2544, Oliver Wyman modeled two scenarios to account for differences in assumptions related to the current allowed amount. The first assumes the payor's median negotiated rate with participating providers for the same emergency service among all of its participating providers. The second assumed that the current allowed amount represents the payor's UCR amount for the same emergency service. Oliver Wyman found that under the median negotiated rate, there was a total expected impact of +3.6% increase, but that there was a broad range of -35.6% to +108%. If the Usual, Customary, and Reasonable rate was assumed, there was an overall anticipated impact of +38.5% but includes wide regional variances from +12.6% to +126.6%. The ranges are even more significant for facility claims.

When modeling for all medical and prescription drug services, the expected impact assuming the median negotiated rate is 0.0%. If the Usual and Customary Rate is assumed, the expected impact on allowed costs is 0.1%.

Using the 200% of Medicare proposal, the impact of reimbursing emergency services delivered by non-participating providers within the Commonwealth at 200% of Medicare is expected to lead to a change in allowed costs of -11.9% for services delivered by health care professionals and -24.4% for services delivered by facilities.

Within the set of services delivered by health care professionals, professionals providing services for emergency department visits and anesthesia services could be expected to observe more significant reductions in overall allowed cost (-42.5% and -45.9% reductions, respectively). Healthcare professionals could be expected to observe an increase in allowed costs for other emergency services. This policy option could result in a significantly different impact by region, from a decrease of -56.9% to an increase of +67.2%. Regional variation is much broader for facility services than for services of a health care professional.

For allowed claims for all medical and prescription drug services , this proposal could be expected to decrease overall allowed costs by approximately -0.1% on average, ranging by

region from -0.4% to +0.2%. This is based upon a combined analysis of fully and self-insured data received from the payors.

Network Impacts

One of the key considerations of the balance billing issue, during previous General Assembly discussions and throughout the workgroup, is the potential impact on networks especially that of the Virginia State Employee Health Plan, but also throughout carrier lines of business. The health plans felt that the imposing balance billing protections carried the risk of providers preferring to leave networks or remain out of networks, thus resulting in narrower networks and increasing the incidences where an individual would be seen by an out-of-network provider.

Some provider groups stated that balance billing protections would not lead to abandoning networks, however, it was necessary to identify some measure of predictability.

Using limited available data, Oliver Wyman and DHRM provided an analysis of what Virginia might expect under each proposal in both the commercial market and state employee health plans. This analysis focused on the variance from in-network rates, by percent of claims, to help predict whether providers would have a financial incentive to leave a network or to remain out of network.

The analysis of HB 1744 showed over 30% of claims (as measured by allowed costs) for emergency anesthesia services delivered by participating providers would be expected to realize an increase in the allowed amount of more than 75%; and, roughly 50% of claims would be expected to realize an increase in the allowed amount of more than 25%. Likewise, roughly 35% (as measured by allowed costs) of claims for emergency department visits delivered by participating providers would be expected to realize an increase in the allowed amount of more than 25% over current levels.

Under HB 2544, it appeared that the average impact on emergency services was around 0% due to the definition of regional average under current allowed costs. Across all six categories of service, there was an estimated impact of no more than 10% on approximately 36% of claims.

In evaluating the option where a non-participating provider would be required to accept 200% of Medicare as payment in full, most participating providers would be expected to experience an increase in their reimbursement relative to current levels, should the provider cease to be a participating provider. In other words, the current contracted rates with participating providers are generally below 200% of Medicare for most categories of service. The exception is anesthesiologists, who are currently being reimbursed more than 200% of Medicare, and would

experience a decrease in reimbursement if they were to instead be reimbursed at 200% of Medicare.

If chosen, this policy option could result in a significantly different impact by region, with the region modeled to experience the lowest overall impact potentially experiencing an average change in allowed costs of -56.9% and the region modeled to experience the highest overall impact potentially experiencing an average change in allowed costs of +67.2%. There is significant variation between facility services and services of a health care professional. When examining this proposal enactment could be expected to decrease overall allowed costs by approximately -0.1% on average, ranging by region from -0.4% to +0.2%.

Network Impacts on the State Employee Health Plan

After accounting for data limitations and other factors impacting costs and networks, Aon, actuary for the DHRM, found that the estimated cost impact to state employee health plans for FY 2021 under each proposal would be: HB 1714: $3.5-$7.0 million; HB 2544: $0.3M-$1.5M; and, 200% Medicare: $4.6-$9.3M. As stated in previous sections, any of the three proposals is expected to have an impact of less than $10 million, which represents less than a 1% cost increase in total expected FY2021 plan paid claims. However, there could be longer term impacts due to outlier provider categories, as they could potentially use out-of-network emergency services as leverage in their contract negotiations.

While the group did not reach agreement on a particular proposal to introduce in the 2020 General Assembly session, the analyses provided by the BOI and the DHRM represent the best data and evaluation of the issue in Virginia available at this time. The results presented should be taken into consideration in examination of future policy proposals.

Actuarial Analyses of Policy Options to Address Surprise Billings for Out-of-Network Emergency Services in Virginia for State Employees

Supplement to the Oliver Wyman Report Dated December 31, 2019

December 31, 2019

As a supplement to the out-of-network emergency services surprise billing analysis provided for the Commonwealth of Virginia by Oliver Wyman, Aon estimated the cost impact to the state employee health plan for the three options as outlined in their report.

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The impact to plan costs goes beyond the change in reimbursement for out-of-network emergency services. There is also a cost associated with participating providers seeking greater reimbursement by either leaving the network or negotiating better contracts. To evaluate the likelihood of each provider seeking better reimbursement, we need data that includes all emergency and non-emergency claim detail by provider over a multiple year period. There was not ample time to collect and analyze this level of claim detail. Using the data that we do have, we valued each in-network professional emergency service claim record at the greater of the current amount and the amount under each of the proposed options. Following this approach has limitations such as the following:

- The portion of the emergency services included in the data that are associated with providers that also perform non-emergency services is unknown. Some providers may continue to have a financial incentive to stay in-network when considering their contracts for all services.
- While it is unlikely for a facility to leave the network seeking greater reimbursement for emergency room claims, a facility may use any new out-of-network provider payment requirements for emergency services in their contract negotiations.
- Some providers may negotiate a reimbursement above what is paid to out-of-network providers for emergency services under the proposed options.

Considering the limitations of the data as outlined above, we estimate the FY2021 plan paid claims cost impact to the network participation/contracts to be as follows:

	Cost Impact to Network Participation/Contracts		
	HB 1714	HB 2544	200% Medicare
FY2021 Plan Paid Cost Impact	$3.5M - $7.0M	$0.3M - $1.5M	$4.6M - $9.3M

The total FY2021 cost impact under the three options is not expected to exceed $10.0M, which represents less than a 1% cost increase in total expected FY2021 plan paid claims.

The potential for long-term plan cost impacts still exists. For example, other provider groups, such as anesthesiologists, may use the change to the reimbursements for out-of-network emergency services as leverage in their contract negotiations. This potential cost impact is beyond the scope of this analysis.

OLIVER WYMAN

ACTUARIAL ANALYSES OF POLICY OPTIONS TO ADDRESS SURPRISE BILLING FOR OUT-OF-NETWORK EMERGENCY SERVICES IN VIRGINIA

VIRGINIA BUREAU OF INSURANCE

DECEMBER 31, 2019

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MARSH & McLENNAN COMPANIES

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1. Executive Summary

Under current Virginia law, non-participating providers delivering emergency services within the Commonwealth may bill individuals covered by commercial insurance for the amount by which their chargemaster exceeds the amount a health carrier is required to pay under §38.2-3445. Many times, even when receiving services at a participating (i.e., in-network) facility, individuals are unaware that one or more health care professionals from whom they receive services are non-participating providers and the practice of balance billing can lead to surprise bills, sometimes in the tens of thousands of dollars.

At the request of the Balance Billing Work Group, Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) was engaged by the Virginia Bureau of Insurance (the Bureau) to conduct actuarial analyses to estimate the potential impact on reimbursement to non-participating providers delivering emergency services within the Commonwealth, as well as health insurance premiums, under three policy options. Each of these options is aimed at protecting insured individuals by prohibiting the practice of balance billing and setting a benchmark for determining the amount that the non-participating provider must accept as payment in full. The three policy options analyzed include:

1. House Bill 1714 (see Appendix A)
2. House Bill 2544 (see Appendix B)
3. A reimbursement benchmark equal to 200% of Medicare

Data Sources

In order to produce the most reliable results when comparing multiple policy options, it is critical to select a single data source to be used for all analyses performed. Using a single data source will eliminate the possibility that some portion of the difference in measured results could be attributed to differences in the underlying data. In consultation with the Bureau, it was determined that the analyses should be based on information obtained from a data call to health carriers that offered coverage in Virginia's commercial market in 2017. Data were provided by Aetna, Anthem, CareFirst, Cigna, Kaiser, Optima, and Piedmont. These health carriers represent approximately 91% of the total commercial health premiums earned and 89% of the covered lives for 2017. Information was requested from UnitedHealthcare, but the carrier was unable to meet the strict reporting deadline necessary for this project.

Methodology

Emergency services are defined in §38.2-3438, however this definition could not be directly translated to the health carrier data. We worked with the Bureau to develop a set of criteria that could be applied to the claims data that best aligned with the definition of emergency services outlined in statute. Ultimately, any claim that met one of the following criteria were categorized as an emergency service for purposes of our analyses:

- The claim was delivered within an emergency department (identified as having the place of service field on the claim record populated with a value of 23).
- The claim was provided in an inpatient facility setting of a hospital that has an emergency department (identified as having the place of service field on the claim record populated with a value of 21), and at least one claim for a service provided in the

emergency department was present for the same individual with a date of service equal to the admission date of the inpatient claim.

Current law requires that when emergency services are delivered by a non-participating facility or health care professional within the Commonwealth, a health carrier is required to provide benefits in an amount equal to the greatest of (1) the median amount negotiated with in-network providers, (2) the health carrier's usual, customary, and reasonable (UCR) amount; and (3) the amount Medicare would allow for the emergency service. Therefore, it was assumed that the value currently reflected in the allowed amount field for these claims is the greatest of the three items listed. Further, it was assumed that this amount was always greater than or equal to 100% of Medicare.

When evaluating the three policy options considered, there were certain additional methodological considerations specific to one or more of the policy options. Notable items include:

HB 1714

- Regional averages for each CPT/HCPCS code were calculated as the straight average of the health carriers' medians (i.e., each carrier's median was given equal weight) within the region, based on experience for emergency services delivered by both participating and non-participating health care professionals.
- Fair market value of emergency services delivered by facilities within the Commonwealth were unavailable. Therefore, when evaluating HB 1714, the proponents of the bill recommended we model the expected impact by increasing the allowed cost of these services by 25% and separately increasing them by 45%, to produce a range consistent with their expectations.

HB 2544

- The regional averages for each CPT/HCPCS code were calculated as the average allowed cost within each region, using only experience for emergency services delivered by participating health care professionals and facilities, separately for each carrier and region, and separately for services delivered by health care professionals vs. those provided by facilities.
- The regional averages for each DRG were calculated as the average allowed cost within each region, using only experience for emergency services delivered by participating facilities, separately for each carrier.
- For services of non-participating facilities delivered within an emergency department setting, the impact on those services that don't utilize CPT/HCPCS codes (i.e., those that utilize only revenue codes) was assumed to equal the average impact on those services that do utilize CPT/HCPCS codes, for that health carrier and region.
- Since it was unknown whether the allowed amount currently present on each claim represents the carrier's median amount negotiated with in-network providers or their UCR amount, two scenarios were modeled. In one scenario it was assumed the current allowed amount represents the carrier's median amount negotiated with in-network providers and in the other it was assumed to represent the carrier's UCR amount.
- For those CPT/HCPCS or DRG codes for which a regional average could not be calculated for a given health carrier and region, the impact on any claims for emergency services delivered by a non-participating provider within the Commonwealth was

assumed to be equal to the average impact on those services that could be analyzed, for that provider type (i.e., health care professional or facility), health carrier, and region.

Alternate Proposal – 200% of Medicare

- An estimate of the allowed amount at 200% of Medicare could not be developed for inpatient emergency services delivered by a nonparticipating facility, due to the fact that Medicare reimbursement varies by hospital and the rendering facility was not identified on the claims data provided. Therefore, the impact on these claims was assumed to be equal to the average impact on emergency services delivered within an emergency department for non-participating facilities, for the same health carrier within that same region.
- While Medicare does not allow for a separate payment to be made for services delivered within an emergency department when the individual is admitted from the emergency department, we assumed that under this policy option a payment would still be required to be made and would be equal to two times the amount Medicare would have allowed had the individual instead been discharged from the emergency department.

Results

The following table presents the modeled impact on allowed claims for emergency services that were delivered by non-participating health care professionals and facilities within the Commonwealth, under each of the policy options and scenarios modeled. We present the overall average impact separately for predominant types of services delivered by health care professionals, facilities, and then in aggregate across all emergency services delivered by non-participating providers within the Commonwealth. The table shows that under the various options studied, the average expected change to reimbursement for emergency services delivered by non-participating health care professionals and facilities within the Commonwealth ranges from -19.7% to +39.1%.

			Average Impact on Allowed Costs				
Provider Type	**Category of Svc.**	**% of Claims[1]**	**HB 1714 FMV=+25%**	**HB 1714 FMV=+45%**	**HB 2544 Median**	**HB 2544 UCR**	**200% Medicare**
Professional	ED Visits	17.0%	13.2%	13.2%	-45.3%	7.0%	-42.5%
Professional	Other E&M	7.1%	19.0%	19.0%	-7.5%	16.9%	45.3%
Professional	Surgical	7.0%	40.5%	40.5%	-33.4%	13.2%	5.0%
Professional	Anesthesia	3.3%	119.9%	119.9%	-24.1%	29.8%	-45.9%
Professional	Phys. Med.	2.3%	24.1%	24.1%	-20.1%	15.1%	9.7%
Professional	Other Emergency	1.4%	21.0%	21.0%	-30.3%	12.2%	30.9%
Professional		38.1%	29.6%	29.6%	-32.1%	12.7%	-11.9%
Facility		61.9%	25.0%	45.0%	25.5%	54.3%	-24.4%
Total		**100.0%**	**26.7%**	**39.1%**	**3.6%**	**38.5%**	**-19.7%**

[1] Represents the percent of all claims for emergency services delivered by non-participating providers within the Commonwealth

In addition, we also estimated the impact on overall allowed claims across all medical and prescription drug services. This provides a proxy for the estimated impact on health insurance premiums. As the table below shows, the estimated average premium impact ranges from -0.1% to +0.1%. Please note that both the results in the table below and the preceding table observe wider variation when examined by region.

			Average Impact on Allowed Costs				
Provider Type	**Category of Svc.**	**% of Claims[1]**	**HB 1714 FMV=+25%**	**HB 1714 FMV=+45%**	**HB 2544 Median**	**HB 2544 UCR**	**200% Medicare**
Professional	Non-Par Emergency[1]	0.1%	29.6%	29.6%	-32.1%	12.7%	-11.9%
Facility	Non-Par Emergency[1]	0.2%	25.0%	45.0%	25.5%	54.3%	-24.4%
All	All Other	99.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Total		**100.0%**	**0.1%**	**0.1%**	**0.0%**	**0.1%**	**-0.1%**

[1] Represents all claims for emergency services delivered by non-participating providers within the Commonwealth

The above results are based on the combined fully and self-insured data which was received from the health carriers. We also reviewed the impact when utilizing only the fully-insured data. There was no change to the regional averages used in the analyses as our understanding is that these values should be based on the combined data. The table below presents the modeled impact on allowed claims for emergency services that were delivered by non-participating health care professionals and facilities within the Commonwealth, under each of the policy options and scenarios modeled, when limited to only fully insured data. When comparing the impact by funding type (i.e., fully-insured only vs. combined fully and self-insured), there was minimal difference in the percentage impact for the professional provider type. However, there was a significant decrease in the impact for the facility provider type which ranged between 14% and 39%, excluding HB 1714 where the facility impact was set to be the same.

		Average Impact on Allowed Costs (Fully-Insured Only)				
Provider Type	**% of Claims[1]**	**HB 1714 FMV=+25%**	**HB 1714 FMV=+45%**	**HB 2544 Median**	**HB 2544 UCR**	**200% Medicare**
Professional - Total	37.9%	29.7%	29.7%	-31.3%	12.3%	-11.9%
Facility - Total	62.1%	25.0%	45.0%	7.1%	40.0%	-63.3%
Total	**100.0%**	**26.8%**	**39.2%**	**-7.5%**	**29.5%**	**-43.9%**

[1] Represents the percent of all claims for emergency services delivered by non-participating providers within the Commonwealth

The table below presents the modeled impact on allowed claims across all medical and prescription drug services, when limited to only fully insured data. The difference in the total impact between funding types ranges from -0.12% (200% of Medicare) to +0.05% (HB 1714, FMV = +45%). This difference is a result of a change in the impact for the facility provider type as discussed in the first table as well as a slightly larger percentage of claims for emergency services delivered by non-participating providers within the Commonwealth when using fully-insured data only.

			Average Impact on Allowed Costs (Fully-Insured Only)				
Provider Type	Category of Svc.	% of Claims[1]	HB 1714 FMV=+25%	HB 1714 FMV=+45%	HB 2544 Median	HB 2544 UCR	200% Medicare
Professional	Non-Par Emergency[1]	0.1%	29.7%	29.7%	-31.3%	12.3%	-11.9%
Facility	Non-Par Emergency[1]	0.2%	25.0%	45.0%	7.1%	40.0%	-63.3%
All	All Other	99.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Total		**100.0%**	**0.1%**	**0.2%**	**0.0%**	**0.1%**	**-0.2%**

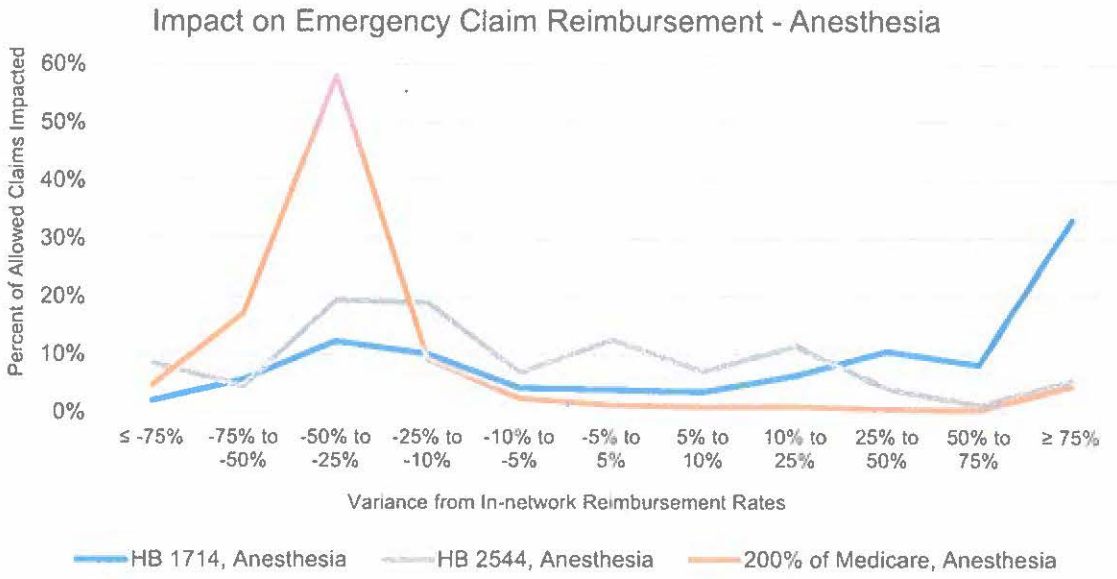
[1]Represents all claims for emergency services delivered by non-participating providers within the Commonwealth

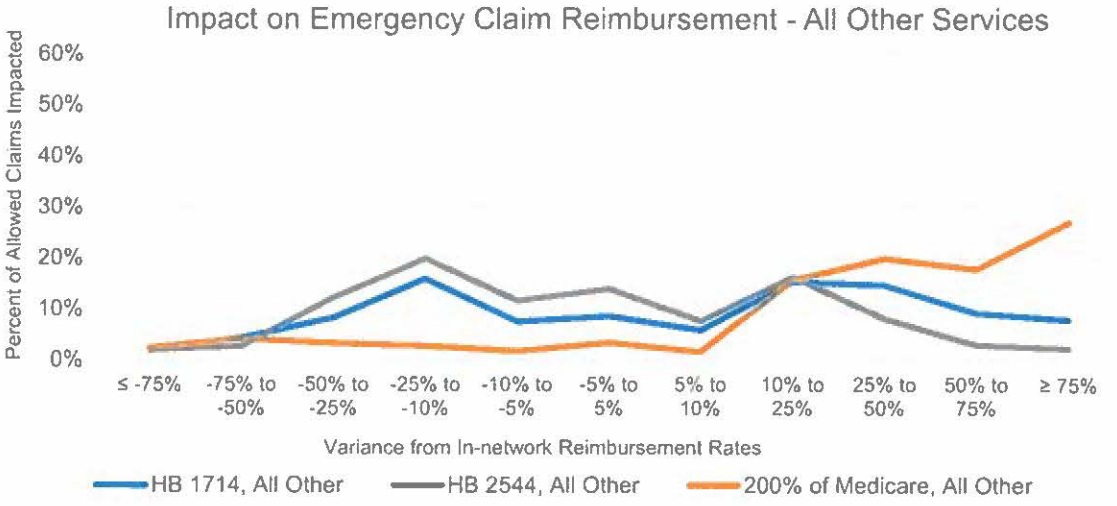
Network Participation

Finally, to assist the Bureau and other key stakeholders in assessing the potential impact that these policy options could potentially have on network participation among health care professionals we performed a high-level analysis based on the data that was available, noting its limitations. We compared the allowed charge amount available on claims for emergency services delivered by participating health care professionals, with the reimbursement those providers could instead be expected to receive as a non-participating provider, under each of the three policy options.

We note that the applicable benchmark reimbursement amounts under HB 1714 and HB 2544 are the greatest of several items listed in the draft Bills, which could not be calculated given the health carrier's corresponding median amount negotiated with in-network providers and UCR amount for the claim are unknown. Therefore, our analyses were limited to a comparison of the negotiated allowed amounts present on claims for these in-network services and the applicable regional averages that would apply under these two policy options, noting that as a non-participating provider the health care professional would receive reimbursement greater than or equal to this amount under these two policy options. For the third policy option where the benchmark reimbursement amount would be equal to 200% of Medicare, the allowed amounts present on the claims for in-network services were compared to an estimate of reimbursement at 200% of the 2017 Medicare allowed amount. Since a facility will be much less likely to terminate its network participation agreement as a result of the policy options studied, these analyses were limited to only services delivered by health care professionals.

The chart and table below present the results. The results were similar for each of the categories of service examined, with the exception of anesthesia. Therefore, the information below is shown for anesthesia services, and collectively for all other services of health care professionals, for each policy option. In addition, the information below is presented only for combined fully and self-insured data as the results and takeaways when utilizing only fully-insured data are extremely similar. The x-axis represents the expected impact on allowed claims, and the y-axis shows the percent of total allowed claims for that type of service and policy option that would be expected to have the stated impact on reimbursement.





Distribution of Allowed Claims by Variance from In-network Reimbursement Rates

	HB 1714		HB 2544		200% Medicare	
Variance from In-network Reimbursement Rates	**Anesthesia**	**All Other**	**Anesthesia**	**All Other**	**Anesthesia**	**All Other**
≤ -25%	20%	14%	32%	17%	80%	10%
-25% to +25%	28%	53%	57%	70%	15%	25%
≥ +25%	52%	32%	11%	14%	5%	65%
	100%	100%	100%	100%	100%	100%

Totals of rows for each column may not sum to 100% due to rounding

2. Introduction

Under current Virginia law, in addition to any patient cost sharing (e.g., deductible, coinsurance, copay) required under the provisions of their health insurance policy, an individual receiving treatment for emergency services as defined under §38.2-3438 may be required to pay the excess of the amount that a non-participating (i.e., out-of-network) provider charges over the amount the health carrier is required to pay under §38.2-3445. The practice of charging individuals this excess amount is commonly referred to as balance billing and will be referred to as such in this report. Many times, even when receiving services at a participating (i.e., in-network) facility, individuals are unaware that one or more health care professionals from whom they receive services are non-participating providers and the practice of balance billing can lead to surprise bills, sometimes in the tens of thousands of dollars.

At the request of the Balance Billing Work Group, Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) was engaged by the Virginia Bureau of Insurance (the Bureau) to conduct actuarial analyses to estimate the potential impact on health insurance premiums and total reimbursement to non-participating providers delivering emergency services within the Commonwealth, under three policy options. Each of these options is aimed at protecting insured individuals from surprise bills when receiving emergency services delivered by a non-participating health care professional or facility within the Commonwealth, by prohibiting the practice of balance billing and setting a benchmark for determining the amount that the non-participating provider must accept as payment in full. The three policy options analyzed include:

4. House Bill 1714 (see Appendix A)
5. House Bill 2544 (see Appendix B)
6. A reimbursement benchmark equal to 200% of Medicare

Policy solutions that are expected to reduce payments to non-participating providers, relative to current levels, would have a favorable impact on premiums however they would reduce income to those providers, and could lead to financial issues for certain providers and potential care access issues. On the other hand, solutions that increase payments to non-participating providers, relative to current levels, would have an unfavorable impact on premiums and if the payment level is set too high it could lead to an unintended incentive for participating providers to no longer participate in the network if they are able to receive much higher payments as a non-participating provider. Therefore, the Bureau has also asked Oliver Wyman to provide any additional analyses that could be produced, using the data that was made available by the health carriers and recognizing its limitations, that might assist key stakeholders and policymakers in assessing the potential impact that each option could have in terms of network disruption.

It is important to note that Oliver Wyman is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute, nor is it a substitute for, legal advice. Accordingly, Oliver Wyman recommends that the Bureau secure the advice of competent legal counsel with respect to any legal matters related to this report or otherwise. This report is intended to be read and used as a whole and not in parts. Separation or alteration of any section or page from the main body of this report is expressly forbidden and invalidates this report.

3. Data Sources

In order to produce the most reliable results when comparing multiple policy options, it is critical to select a single data source to be used for all analyses performed. If different data sources were used to analyze different policy options, some portion of the difference in measured results would arguably be attributed to differences in the underlying data. One of the policy options being studied, HB 1714, states that the "regional average for commercial payments," which is used in determining the benchmark reimbursement for professional services delivered by non-participating providers in the Commonwealth, should be "based on data submitted by data suppliers in 2017 pursuant to subdivisions B 1 and 2 of §32.1-276.7:1 and reported to the Commission's Bureau of Insurance by the nonprofit data services organization…."

As a result of this definition, 2017 claims from the Virginia All Payer Claims Database (APCD) and regional averages published by Virginia Health Information (VHI) were the initial data sources considered for our analyses. However, in discussing the feasibility of using the APCD data and the published regional averages with the Bureau and VHI, it was ultimately determined that they would not represent a valid data source for the analyses, for the following reasons:

1. The indicator on the APCD data used to identify whether a claim was representative of a service delivered by a participating or non-participating provider was not consistently populated within the data, making it impossible to accurately segregate claims for emergency services delivered by non-participating providers within the Commonwealth.

2. The subset of codes for which regional averages were made publicly available by VHI only represented a small percentage of the claims for emergency services delivered by non-participating providers within the Commonwealth (i.e., those which would be subject to potential adjustment under the policy options being studied). It was not feasible for VHI to calculate regional averages for all of the necessary CPT/HCPCS codes using the APCD data in the required timeframe for completing the analyses.

3. The regional averages published by VHI were developed for purposes other than this study, and for certain CPT/HCPCS codes the regional averages were episodic based (i.e., they represented costs for all services associated with an encounter and not only the costs for the listed CPT/HCPCS code). As a result, the calculated averages did not represent the average allowed amounts at a CPT/HCPCS code level which were needed for our analyses.

4. Consideration and adjustment for the impact that payment modifiers have on the allowed amounts present on claim records was not accounted for in the regional averages published by VHI, which could have a significant impact on our analyses for certain CPT/HCPCS codes where payment modifiers are commonly used (e.g., radiology services where only the technical or professional component is being billed, surgeries where multiple procedures and bilateral procedures are performed, etc.). It was not feasible for VHI to recalculate the published regional averages to account for the presence of payment modifiers in the timeframe available for completing the analyses.

5. The geographic region definitions that underlie the regional averages published by VHI data were based on member ZIP code, while geographic region definitions based on provider ZIP code were necessary for completing our analyses.

In consultation with the Bureau, it was therefore determined the data source underlying the analyses should be based on information obtained from a data call to the health carriers which offered coverage in Virginia's commercial market in 2017, since a consistent data source was desired for all components of the analyses and the APCD data and regional averages published by VHI could not be utilized for the reasons outlined above. The data collected from the health carriers was limited to claims with dates of service between January 1, 2017 and December 31, 2017, to coincide with the requirements of HB 1714. Information was received from the following carriers and utilized in the analysis: Aetna, Anthem, CareFirst, Cigna, Kaiser, Optima, and Piedmont. These health carriers represent approximately 91% of the total commercial health premiums earned and 89% of the covered lives for 2017. Information was requested from UnitedHealthcare, but the carrier was unable to meet the strict reporting deadline necessary for this project. Therefore, this report does not include information from any UnitedHealthcare carrier. In addition, both fully and self-insured information was requested from all carriers, but self-insured data was not received from Aetna, CareFirst, or Cigna. The split between fully and self-insured allowed claims for all data received was about 41% vs 59%, respectively. Please note that both fully and self-insured data was utilized throughout these analyses.

The data call consisted of two primary extracts, one containing data at the claim line level for all claims that reflected a place of service equal to 21 (Inpatient Hospital) or 23 (Emergency Room), and a second file containing relatively aggregated claims data for all medical and prescription drug services covered under the respective health insurance policies. The claim line detail was used in determining the impact of each policy option being analyzed on the specific claims which had the potential to be affected (i.e., claims for emergency services delivered by non-participating providers within the Commonwealth). The aggregated data was used in estimating the overall impact on total allowed claims for each of the policy options being analyzed. Each carrier provided reconciliation information so we could verify that there was consistency with the information they provided compared to what was used in our analyses.

All claim detail necessary for our analyses was requested, and where available, included on the data extracts provided by the health carriers so that each policy option could be evaluated using the same data source. While the health carriers could not populate some of the fields requested due to unavailability of the information or time constraints (e.g., they could not identify whether a claim was associated with a single case agreement, emergency-only participation agreement, or rental network agreement), they were able to populate the information most critical to our analyses. This detail included information such as whether the service that was the subject of the claim was delivered by a participating or non-participating provider, an indicator to identify whether the claim was billed by a facility or a health care professional, member and provider ZIP code information for determining the VHI geographic region, CPT/HCPCS/DRG/Revenue Codes, CPT/HCPCS modifiers, and the allowed and paid cost information associated with the claim. Any limitations of the data provided by the health carriers, along with how those limitations were addressed in our analyses, are discussed further in the Methodology section of this report.

In order to assess the potential impact of using the data provided by the health carriers versus the APCD data, VHI logic for calculating regional averages was applied to the health carrier data for a sampling of the most popular CPT/HPCS codes used with emergency services. The regional averages we calculated using the health carrier data provided to us were reasonably consistent with the regional averages published by VHI when using their logic, for CPT/HCPCS codes where the published regional average was not episodic based. This comparison provided an additional layer of validation that utilizing the health carrier data would not result in

conclusions that were significantly different than those that would have been drawn, had the APCD data been able to have been used.

A summary of the allowed dollars present in the claims data provided by the health carriers is summarized in the table below. Please note that each row represents a subset of the row immediately preceding it, in order to provide the reader with a sense of how each cohort of claims relates to the broader group to which it belongs. As noted below, the definition used to identify emergency services within the data is discussed in greater detail within the Methodology section that follows.

Description	Allowed Dollars
Aggregated Claims Data Received from Health Carriers[1]	$13,654,387,985
Claims for Services Identified with Place of Service 21 or 23	$4,193,332,936
Emergency Services[2]	$1,507,903,281
Emergency Services Delivered by Non-Participating Providers	$88,182,500
Emergency Services Delivered by Non-Participating Providers within the Commonwealth[3]	$37,286,626

[1] Claims for services covered by commercial health insurance policies, issued to employers located and individuals residing within the Commonwealth of Virginia

[2] See the Methodology section of the report for an explanation of the definition applied to the health carrier data in identifying "emergency services" for purposes of these analyses

[3] Those claims which will potentially be impacted by the policy options analyzed

The following observations can be made from the information in the table above, again noting that emergency services were identified within the health carrier data using the definition outlined in the Methodology section of the report:

1. Allowed claims for emergency services represent roughly 11.0% of allowed claims for all services covered by the health insurance policies underlying the data provided.
2. Allowed claims for emergency services delivered by non-participating providers represent roughly 5.8% of allowed claims for all emergency services and only 0.6% of allowed claims for all services covered by the health insurance policies underlying the data provided.
3. Allowed claims for emergency services delivered by non-participating providers within the Commonwealth represent roughly 2.5% of allowed claims for all emergency services, and only 0.3% of all allowed claims for services covered by the health insurance policies underlying the data provided.
4. Allowed claims for emergency services delivered by non-participating providers within the Commonwealth represent roughly 42.3% of allowed claims for all emergency services delivered by non-participating providers; the remaining 57.7% are delivered by non-participating providers located outside of the Commonwealth (i.e., where the Service Provider ZIP Code was not a Virginia ZIP Code).

We have relied on the data provided by the health carriers for our analyses. We have not audited or independently verified this data; however, it has been reviewed for reasonableness and consistency with summaries provided by the health carriers, and no material defects in the data have been found. A detailed audit of the data was beyond the scope of our engagement with the Bureau and it is possible that if an audit were conducted inaccuracies in the data could

be revealed. If the data is inaccurate or incomplete, the results of the analysis may also be inaccurate or incomplete.

4. Methodology

In this section we present the methodology that underlies the analyses performed. We first discuss the methodology used to identify emergency services in the data, the criteria used to define the geographic regions, and a deviation in the outlined methodology for anesthesia claims for one health carrier given a limitation with the data they provided. We then present the methodology used, including general methodology and assumptions, along with any additional methodology unique to each policy option analyzed. We describe the methodology used to develop the applicable benchmark reimbursement amounts that non-participating facilities and health care professionals would be required to accept as payment in full when delivering emergency services within the Commonwealth, along with how those benchmarks were applied to the claims data for emergency services provided by non-participating providers in order to estimate the impact that each policy option would have on allowed costs.

Emergency Services

Emergency services are currently defined in §38.2-3438 as:

> *"Emergency services" means with respect to an emergency medical condition: (i) a medical screening examination as required under §1867 of the Social Security Act (42 U.S.C. §1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under §1867 of the Social Security Act (42 U.S.C. §1395dd(e)(3)) to stabilize the patient.*

The Bureau advised us that the definition above should be interpreted to include all healthcare services required to be provided under the Emergency Medical Treatment and Labor Act (EMTALA). More specifically, the Bureau advised us that in addition to services delivered within an emergency department of a hospital, this definition should be interpreted to also apply to services provided within an inpatient setting of a hospital provided to a patient that has not been stabilized at the time they are admitted from the emergency department.

Since the data used for the analyses represents adjudicated claims data, it does not contain any clinical information that would indicate the patient's physical status at the time a service was provided. Therefore, it was unknown whether the individual who received the service was in stable condition at the time they initially sought care at the emergency department, became stable at some point while being treated within the emergency department, or for those individuals who were admitted from the emergency department, whether they were in stable condition at the time of admission or at what point after being admitted they became stabilized. Therefore, we discussed with the Bureau options for identifying which claims within the data would best correlate with the definition of emergency services as outlined in §38.2-3438. Ultimately, it was agreed that emergency services for purposes of these analyses should be defined as all claims that met one of the following criteria:

- The claim was delivered within an emergency department (identified as having the place of service field on the claim record populated with a value of 23).

- The claim was provided in an inpatient facility setting of a hospital that has an emergency department (identified as having the place of service field on the claim record populated with a value of 21), and at least one claim for a service provided in the emergency department was present for the same individual with a date of service equal to the admission date of the inpatient claim.

Our understanding is that the Bureau acknowledges that the criteria outlined above are likely to result in classifying some claims as emergency services that likely do not meet the statutory definition. However, given the limitations of the information present on adjudication claims data (e.g., the lack of information as to whether the patient was in stable condition or not at the time the service was delivered) there was no feasible way to separate these claims out. Throughout the remainder of this report, the term "emergency services" will be used to describe those that meet this definition.

Definitions of Geographic Region

Two of the policy options analyzed, HB 1714 and HB 2544, require that the benchmark for determining the amount that the non-participating provider must accept as payment in full varies by geographic region for one or more of the components considered. However, neither of these bills prescribe the number of geographic regions to be used or define them in any way, although HB 2544 does indicate that the regions shall be defined by the Virginia State Corporation Commission. In discussing this with the Bureau it was determined that the geographic regions utilized by VHI should be used for our analyses. These definitions are summarized in the following table.

Region	Counties/Independent Cities
Central	Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Colonial Heights City, Cumberland, Dinwiddie, Emporia City, Goochland, Greensville, Halifax, Hanover, Henrico, Hopewell City, Lunenburg, Mecklenburg, New Kent, Nottoway, Petersburg City, Powhatan, Prince Edward, Prince George, Richmond City, Surry, Sussex
Eastern	Accomack, Chesapeake City, Essex, Franklin City, Gloucester, Hampton City, Isle of Wright, James City, King and Queen, King William, Lancaster, Mathews, Middlesex, Newport News City, Norfolk City, Northampton, Northumberland, Poquoson City, Portsmouth City, Richmond, Southampton, Suffolk City, Virginia Beach City, Westmoreland, Williamsburg City, York
Northern	Alexandria City, Arlington, Clarke, Fairfax, Fairfax City, Falls Church City, Loudoun, Manassas City, Manassas Park City, Prince William
Northwestern	Albemarle, Augusta, Bath, Buena Vista City, Caroline, Charlottesville City, Culpeper, Fauquier, Fluvanna, Frederick, Fredericksburg City, Greene, Harrisonburg City, Highland, King George, Lexington City, Louisa, Madison, Nelson, Orange, Page, Rappahannock, Rockbridge, Rockingham, Shenandoah, Spotsylvania, Stafford, Staunton City, Warren, Waynesboro City, Winchester City
Southeastern	Alleghany, Amherst, Appomattox, Bedford, Bland, Botetourt, Bristol City, Buchanan, Campbell, Carroll, Covington City, Craig, Danville City, Dickenson, Floyd, Franklin, Galax City, Giles, Grayson, Henry, Lee, Lynchburg City, Martinsville City, Montgomery, Norton City, Patrick, Pittsylvania, Pulaski, Radford, Roanoke, Roanoke City, Russell, Salem, Scott, Smyth, Tazewell, Washington, Wise, Wythe

Anesthesia Services

Reimbursement for anesthesia services delivered by a health care professional are typically a function of a base conversion rate multiplied by units, where the units are typically comprised of three components: (1) base units assigned to the procedure which vary based on the CPT code, (2) time units which are a function of the number of minutes from the time the anesthesiologist prepares the patient until the anesthesiologist is no longer in attendance, and (3) physical status units which are a function of modifiers attached to the CPT code. One of the health carriers that submitted data for the study did not populate the units field on the claim record which is meant to capture the time units for anesthesia services. Therefore, their experience for anesthesia claims could not be used as the time units were unknown.

Given the very short time period under which the analyses were required to be performed, the timeline did not allow for an alternate data set to be prepared and provided by the health carrier. As such, anesthesia claims for this health carrier were excluded from the development of the regional averages required to be calculated for the analyses of the policy options under HB 1714 and HB 2544. Further, without the units field populated the anesthesia claims associated with emergency services delivered by non-participating providers within the Commonwealth for this health carrier could not be evaluated to determine the potential impact under each policy option being analyzed. As such, it was assumed that the impact on claims for emergency anesthesia services delivered by a non-participating provider within the Commonwealth for this health carrier was equal to the average impact on all emergency services delivered by non-participating providers within the Commonwealth for this health carrier for the corresponding policy option and geographic region.

Alternate treatments of these claims would have been to assume the policy options being analyzed had no impact on these claims, or that the average impact on these claims was equal to the average impact on emergency anesthesia services delivered by a non-participating provider within the Commonwealth of other health carriers within each region. It should be noted that the claims for emergency anesthesia services delivered by non-participating providers for this health carrier represented 0.56% of allowed costs for all professional anesthesia services delivered by non-participating providers, and 0.01% of allowed costs for all emergency services delivered by non-participating providers. As such, we believe the way in which these claims were assessed will have no material impact on the results.

General Methodology and Assumptions for Estimating the Impact of Benchmark Reimbursement Amounts Under the Various Policy Options Studied

Current law requires that when emergency services are delivered by a non-participating facility or health care professional, a health carrier is required to provide benefits in an amount equal to the greatest of the following:

1. The amount negotiated with in-network providers for the emergency service, or, if more than one amount is negotiated, the median of these amounts;

2. The amount for the emergency services calculated using the same method the health carrier generally uses to determine payments for out-of-network services, such as the usual, customary, and reasonable (UCR) amount; and

3. The amount that would be paid under Medicare for the emergency service

Therefore, it was assumed that the value currently reflected in the allowed amount field of all claim records for emergency services delivered by a non-participating provider within the Commonwealth equals the greatest of the three items listed above. However, which of those three it represents is unknown. We also assumed that the allowed amounts that appear on all claim records for emergency services delivered by non-participating providers within the Commonwealth is greater than or equal to 100% of Medicare (i.e., they represent either the health carrier's median amount negotiated with participating providers statewide, or their UCR amount), and we believe this assumption would hold in almost all, if not all, cases. Please note that this assumption would only have a potential impact on the analyses for HB 2544.

Certain components of the policy options studied rely on medians or averages, developed at either the carrier or market level, when determining the benchmark reimbursement amounts that non-participating facilities and health care professionals would be required to accept as payment in full when delivering emergency services within the Commonwealth. When calculating any medians/averages, it is critical that any payment modifiers appearing on claims records be considered, and the corresponding allowed amount adjusted accordingly to ensure that any calculated medians/averages are not unintentionally skewed. CPT/HCPCS modifiers are used to indicate that a service or procedure has been altered by some specific circumstance, but the underlying definition of the service or procedure has not changed. Certain modifiers result in payment adjustments (i.e., payment modifiers) while others are for informational purposes only.

The presence of most payment modifiers typically leads to a reduction in payment, though an increase in payment is associated with some payment modifiers, and therefore when payment modifiers are present on a claim the allowed amount reflected has typically been reduced from the level that would have been allowed had the modifier not been present. Common payment modifiers include, but are not limited to, those that are used to indicate services of an assistant surgeon, a second surgery performed by the same surgeon in the same session, or modifiers used to indicate that only the professional or only the technical component of a radiology procedure was being billed. Therefore, not accounting for the presence of these payment modifiers when calculating medians/averages would tend to produce skewed results, and an understatement of the medians/averages in most, if not all, cases. For certain types of services or procedures where payment modifiers are common, the level of understatement could be significant.

Therefore, prior to calculating any medians/averages, the allowed amounts present on all claim records containing a payment modifier were adjusted to reflect an estimate of the "unmodified" amount in order to put all claims for a given CPT/HCPCS code on the same basis. The allowed amount reflected on these claim records was divided by the applicable payment multiplier to develop the "unmodified" value, or the value that would be appropriate for the claim had the payment modifier not been present. For simplicity, payment multipliers used for each modifier were consistent with those used by Medicare. All medians/averages were then calculated after substituting these "unmodified" allowed amounts for claim records that contained a payment modifier.

Since the resulting regional averages we developed reflect the appropriate reimbursement for a claim without a payment modifier present, the regional averages used in determining the

benchmark reimbursement needed to be adjusted for those claims with a payment modifier present when applying the applicable regional averages as described in the sections below by multiplying the regional average amount for the applicable CPT/HCPCS code and region by the appropriate payment multiplier.

Note that when calculating regional averages for each CPT/HCPCS, we were instructed to use the regional averages resulting from the mathematical calculations; the resulting values were not adjusted for credibility or smoothed in any way as would typically be done if developing a fee schedule. For example, we did not apply any type of smoothing process such as evaluating families of CPT/HCPCS codes to determine the average reimbursement as a percent of Medicare , and then setting the regional average fee for CPT/HCPCS codes in each family equal to the average percent of Medicare that was calculated for the family. As a result, it should be noted that in some cases the regional average for a certain CPT/HCPCS code could potentially be developed from only a few claims; however, since emergency services are highly concentrated within a limited number of CPT/HCPCS codes, the regional averages for the most prevalent CPT/HCPCS codes were likely developed from fully credible data in most cases. Further, rational differences between the regional averages for similar CPT/HCPCS codes may not be present in many cases. For example, the calculated regional average for an MRI without contrast dye may be greater than an MRI with contrast dye within the same region, simply due to the mix of providers underlying the experience for each CPT/HCPCS code. Therefore, while the regional averages that were calculated would not likely be suitable for a published fee schedule, they were calculated consistent with the definitions in HB 1714 and HB 2544 and the manner in which the Bureau requested we calculate them.

HB 1714

Under HB 1714, current law would be revised to prohibit non-participating providers providing emergency services with the Commonwealth from balance billing a member, and define the benchmark reimbursement amounts that non-participating facilities and health care professionals would be required to accept as payment in full when providing emergency services in the Commonwealth as the greatest of the following:

1. The amount negotiated with in-network providers for the emergency service, or, if more than one amount is negotiated, the median of these amounts;
2. The amount for the emergency services calculated using the same method the health carrier generally uses to determine payments for out-of-network services, such as the usual, customary, and reasonable amount;
3. The amount that would be paid under Medicare for the emergency service; and
4. If out-of-network services are provided (a) by a health care professional, the regional average for commercial payments for such service, or (b) by a facility, the fair market value for such services.

Current law requires that the health carrier provide benefits, inclusive of any cost-sharing paid by the member, in an amount equal to the greatest of the first three items listed above; HB 1714 would add the fourth criteria. Therefore, in evaluating the impact that this policy option would be expected to have on allowed claims, the allowed amount currently on claim records for emergency services delivered by non-participating providers within the Commonwealth was

replaced with the amount determined under the fourth item above (when taking into consideration payment modifiers), only if that amount was greater than the allowed amount currently on the claim record.

Health carriers were not able to identify which claims were associated with single case agreements, emergency-only participation agreements, or rental network agreements. Therefore, these claims were considered as services delivered by either a participating or non-participating provider based on how health carriers populated the network indicator field in the claims data provided for the analyses, which presumably was consistent with how the field was populated in their data warehouse.

Health Care Professionals

HB 1714 defines the regional average for commercial payments as:

> *"The fixed price, based on data submitted by data suppliers in 2017 pursuant to subdivisions B1 and 2 of §32.1-276.7:1 and reported to the Commission's Bureau of Insurance by the nonprofit services organization that is determined on the basis of the amounts paid to and the amounts accepted by health care providers, from health carriers by category of providers for comparable out-of-network emergency services, identified by codes, in the community where the services were rendered, including amounts accepted under single case agreements, emergency-only participation agreements, and rental network agreements. Regional average for commercial payments determinations do not include amounts accepted by providers for patients covered by Medicare, TRICARE, or Medicaid."*

As discussed in Section 3, data from the APCD was not able to be used for these analyses for the reasons described therein. As such, the commercial data provided by health carriers was used both to develop the regional averages and for assessing the impact of those regional averages on allowed claims. The regional averages were developed based on comparable services, defined as claims for emergency services with the same CPT/HCPCS. In discussing with the Bureau how these regional averages should be calculated, we were informed that proponents of HB 1714 intend for the regional average for a given CPT/HCPCS to be calculated as the straight average (i.e., unweighted average) of the median allowed amount for each health carrier, within the region. As an example, if three health carriers offering coverage within the Central Region provided data for the analyses, the regional average for CPT code 71045 for the Central Region was calculated as:

> Median Allowed Amount for Carrier A in the Central Region for CPT 71045 = X
> Median Allowed Amount for Carrier B in the Central Region for CPT 71045 = Y
> Median Allowed Amount for Carrier C in the Central Region for CPT 71045 = Z
>
> Regional Average for CPT 71045 for the Central Region = (X+Y+Z) / 3

When calculating each health carrier's median, claims for both participating and non-participating providers were used, after limiting the claims to only those for services provided by health care professionals which met the previously described definition of emergency services. As discussed above, prior to determining the median amount for each health carrier, CPT/HCPCS and region, the allowed amount on any claim record containing a payment modifier was first adjusted to reflect an "unmodified" value, and the median allowed amounts for

each CPT/HCPCS code, region, and health carrier were then developed using the "unmodified" allowed amounts.

HB 1714 indicates that the regional averages should be calculated for each "category of provider" however due to an inconsistency in how health carriers submitting claims data for the analyses populated the provider specialty field, this field could not be used. Therefore, the carrier medians and in turn regional average for a given CPT/HCPCS code were based on all claims for that CPT/HCPCS code within the region, regardless of the type of health care professional that delivered the service, adjusted for any payment modifiers as described above. For example, the regional average for a CPT code that represents a chest x-ray was based on all claims for that CPT code, regardless of whether the chest x-ray was read by an emergency department physician or a radiologist. As another example, the regional average for a CPT code that represents an anesthesia service was based on all claims for that CPT code regardless of whether the service was provided by an anesthesiologist or a nurse anesthetist, however the allowed amount on claims for services delivered by a nurse anesthetist (identified by the presence of the applicable payment modifiers) were first adjusted using the methodology described above to develop an "unmodified" amount.

It should be noted that when examining the top CPT/HCPCS codes as measured by allowed cost, roughly half of all allowed costs for emergency services delivered by non-participating providers were associated with evaluation and management (E&M) codes for emergency department visits (CPT codes 99281-99288) which would typically be billed by a physician specializing in emergency medicine. Some of the other top CPT/HCPCS codes were for either evaluation and management services or specific surgical procedures (e.g., cardiovascular surgery, musculoskeletal surgery), which represent services that would typically be performed by a limited number of physician specialties with similar skill. Therefore, given that we have adjusted for payment modifiers, we do not believe that not being able to vary the regional averages by "category of provider" would significantly affect the calculated financial impact of HB 1714. Further, it is our understanding that the proponents of HB 1714 are comfortable with this approach.

There was not a situation under this option where a claim for an emergency service delivered by a non-participating health care professional within the Commonwealth did not have a calculated regional average to apply in evaluating the impact of HB 1714. This is because HB 1714 directs the regional averages to be based on the claims of both participating and non-participating providers, so therefore the non-participating claims being evaluated were also used in developing the regional averages.

Facilities

HB 1714 adds a new requirement to the three currently outlined in statute when establishing the benchmark reimbursement for emergency services delivered by a non-participating facility within the Commonwealth. However, the new requirement, the fair market value of services, is not captured on claims data nor can it be derived from the elements on a claim record. Therefore, there was no way to measure how the allowed amount currently present on the claim record for these services compares to fair market value. As such, the Bureau engaged in discussions with the Virginia Hospital and Healthcare Association (VHHA) and other proponents of HB 1714 to come to agreement on a reasonable method for analyzing its potential impact on facility claims.

Initially, the proponents suggested that we assume that a specified discount from billed charges be used as a proxy for fair market value. While billed charges would typically be captured on a claim record it was not included in the data we received from the health carriers due to concerns that providing both billed and allowed charges would reveal information about the proprietary contracts between health insurers and providers, and having access to the allowed charge amounts were critical to the analyses for all policy options being considered. VHHA indicated that the fair market value of facility services delivered by non-participating providers within the Commonwealth would always be greater than any of the three amounts outlined in current statute, and therefore the allowed amount for emergency services delivered by non-participating facilities within the Commonwealth would increase under HB 1714, relative to the allowed amount currently on the claim record. After further discussion around the type of analyses that could feasibly be performed, VHHA suggested that we model scenarios where the allowed amount currently present on the claim was increased, with the increase ranging from 25% to 45%.

HB 2544

Under HB 2544, current law would be revised to prohibit non-participating providers delivering emergency services within the Commonwealth from balance billing a member, and define the benchmark reimbursement amounts that non-participating facilities and health care professionals would be required to accept as payment in full when providing emergency services in the Commonwealth as the greatest of the following:

1. The average of the contracted commercial rates paid by the health carrier for the same emergency service in the geographic region, as defined by the Commission, where the emergency service was provided;

2. The amount for the emergency services calculated using the same method the health carrier generally uses to determine payments for out-of-network services, such as the usual, customary, and reasonable amount; and

3. The amount that would be paid under Medicare for the emergency service.

Current law requires that the health carrier provide benefits, inclusive of any cost-sharing paid by the member, in an amount equal to the greatest of items two and three listed above, and "the amount negotiated with in-network providers for the emergency service, or, if more than one amount is negotiated, the median of these amounts." The first item above essentially replaces the health carrier's median rate negotiated for the same emergency service among its participating providers statewide, with the health carrier's average negotiated rate for the same emergency service among its participating providers within the geographic region.

When analyzing the potential impact of HB 2544, the decision of whether or not to replace the allowed amount currently present on claims for emergency services delivered by a non-participating facility in the Commonwealth with another amount is contingent upon what the allowed amount currently on the claim record represents. As previously noted, it was assumed that the value currently appearing in the allowed amount field equals the greatest of the three items listed in current statute. However, which of those three it represents is unknown. Since it was also assumed that the allowed amount currently present on these claims would always be greater than 100% of Medicare, it was assumed that the allowed amount currently on each claim represents either the health carrier's median rate negotiated for the same

emergency service among its participating providers statewide, or the health carrier's UCR amount. Therefore, theoretically, the following logic should be applied:

1. If it were known that the current allowed amount represents the health carrier's median negotiated rate for the same emergency service among all of its participating providers, then the allowed amount currently on the claim should be replaced with the health carrier's regional average negotiated amount for the service if greater than the health carrier's UCR amount; otherwise the current allowed amount should be replaced with the health carrier's UCR amount.

2. If it were known that the current allowed amount represents the health carrier's UCR amount for the same emergency service, then the allowed amount should be replaced with the health carrier's regional average negotiated amount for the service only if it is greater than the allowed amount currently on the claim.

Since the health carrier's median rate negotiated for the same emergency service among its participating providers statewide and the health carrier's UCR amount are unknown, and further it is unknown which of these two amounts is currently present on each claim as the allowed amount, a range was developed for the potential impact of HB 2544 by applying the following logic for the two scenarios described above.

1. In the first scenario, where the current allowed amount is assumed to represent the health carrier's median negotiated rate among all of its participating providers, the allowed amount on the claim record was always replaced with the calculated regional average negotiated rate for the same service for the health carrier. If the carrier's UCR amount is greater than the calculated regional average negotiated rate for the health carrier, then the current allowed amount should be replaced with the UCR amount instead, however this amount is unknown. Therefore, this scenario will tend to slightly understate the expected impact on allowed claims.

2. In the second scenario, where the current allowed amount is assumed to represent the health carrier's UCR amount, the allowed amount on the claim record was replaced with the calculated regional average negotiated rate for the same service for the health carrier only if this newly calculated amount was greater than the allowed amount currently present on the claim record.

Given the limitations of the data available, we believe that the methodology outlined above is the closest approximation for the potential impact of HB 2544 that can be developed.

The commercial data provided by health carriers was used both to develop the regional averages for each health carrier and for assessing the impact of those regional averages on allowed claims. For consistency with the analyses performed when analyzing the impact of HB 1714, a regional average was developed for each health carrier at the CPT/HCPCS level, and in the case of inpatient facility claims, at the DRG level. When calculating these regional averages for each health carrier, only claims for participating providers were used, after limiting the claims to only those for services which met the previously discussed definition of emergency services. As discussed above, prior to determining the regional averages the allowed amounts on all claims containing a CPT/HCPCS code along with a payment modifier were first adjusted to reflect an "unmodified" value. The regional average allowed amounts for each CPT/HCPCS code, region and health carrier were then developed using the "unmodified" allowed amounts.

Given that the regional averages were required to be determined using only claims for emergency services delivered by participating providers, there were cases where a claim for an emergency service delivered by a non-participating within the Commonwealth did not have a regional average to apply when evaluating the impact of HB 2544. Specifically, this occurred when there was a claim for an emergency service delivered by a non-participating health care professional within the Commonwealth, but there was not a corresponding claim for the same CPT/HCPCS or DRG for an emergency service delivered by a participating health care professional, for the same health carrier and region. This also included claims for anesthesia services for one health carrier as previously mentioned. In these cases, the impact of HB 2544 could not be directly evaluated and it was assumed that the impact on that claim was equal to the average impact of HB 2544 on all claims for services delivered by non-participating health care professionals for that health carrier and region, for which a regional average could be developed and the impact of HB 2544 could be directly assessed.

Health carriers were not able to identify which claims were associated with single case agreements, emergency-only participation agreements, or rental network agreements. Therefore, these claims were considered as services delivered by either participating or non-participating providers based on how health carriers populated the network indicator field in the claims data provided for the analyses, which presumably was consistent with how the field was populated in their data warehouse.

Facilities

Additional considerations, beyond those outlined above, applied when evaluating the potential impact that HB 2544 could have on claims for emergency services delivered within an emergency department by a non-participating facility within the Commonwealth. Not all services billed by an emergency department of a hospital utilize CPT/HCPCS codes; some utilize only revenue codes. We did not feel it was reasonable to develop regional averages based on revenue codes for these services given the broad definitions used for most revenue codes and therefore the wide variation in the services and corresponding costs that could be provided and billed using the same revenue code.

For example, services billed using revenue codes in the range 250-259 represent charges for medication produced, manufactured, packaged dispensed, and distributed under the direction of a licensed pharmacist and do not require CPT/HCPCS coding. Further, the value of the drug being billed for when using these codes can range from a few dollars to several hundred dollars. As such, calculating and applying a regional average for these services would result in significant overstatement for certain drugs and significant understatement for others. For those claims for emergency services billed by a facility in an emergency department setting that do not contain a CPT/HCPCS code, the methodology presented above was not applied. Instead, the potential impact of HB 2544 on claims for emergency services delivered within an emergency department by a non-participating facility within the Commonwealth, the impact was estimated as being equal to the average impact on those claims where a CPT/HCPCS was present and for which a regional average could be developed, for that health carrier and region. We note that roughly 88% of allowed costs for emergency services delivered within an emergency department by a non-participating facility within the Commonwealth contained a CPT/HCPCS code, while the remaining 12% were for claims that do not utilize CPT/HCPCS codes.

Additional Proposal - 200 Percent of Medicare

Under this policy option, current law would be revised to prohibit non-participating providers delivering emergency services within the Commonwealth from balance billing a member, and define the benchmark reimbursement amount that non-participating facilities and health care professionals would be required to accept as payment in full when providing emergency services in the Commonwealth. The benchmark reimbursement would be defined as two times the amount that Medicare would allow for the same service. As such, when evaluating the potential impact of this proposal, the allowed amount currently present on all claims for emergency services delivered by non-participating providers within the Commonwealth were replaced with an estimate of two times the amount that Medicare would allow, regardless of the allowed amount currently present on the claim.

Health Care Professionals

In evaluating the potential impact of this policy option on emergency services delivered by non-participating health care professionals within the Commonwealth, an estimate of the amount Medicare would have allowed in the Commonwealth in 2017 was determined. Specifically, in developing these estimates the applicable 2017 values/factors were used for items including, but not limited to, the conversion factor applicable to the RBRVS fee schedule, the geographic practice cost index factors, the conversion rate to be used for anesthesia services, base and frailty units for anesthesia services, the relative value units (RVUs) for the work, practice, and medical malpractice components, and CPT/HCPCS payment modifier applicability and adjustment factors. Given that the emergency services that are the subject of the analyses were delivered in a facility setting, we utilized the practice expense RVUs applicable to a facility setting. Finally, we reviewed the anesthesia data, excluding data for the health carrier that was unable to accurately provide units, to determine the appropriate point at which to assume the units field on claim records represents the number of minutes billed for anesthesia services vs. when it represents the number of units billed for anesthesia services.

Facilities

In evaluating the potential impact of this policy option on emergency services delivered by non-participating facilities within the Commonwealth, an estimate of the Medicare allowed amount was developed based on the amount Medicare would have allowed in the Commonwealth in 2017, based on the information that was available on the claim records. For services delivered in an emergency department setting, hierarchical logic under the Outpatient Prospective Payment System (OPPS) was applied to all claim lines for a given individual where the place of service field was populated with a value of 23 and all claim lines reflected the same date of service, in order to assign an ambulatory payment classification (APC) to the bundled claim. The Medicare allowed amount was then estimated for the assigned APC, and multiplied times two to determine the revised allowed amount for the entire encounter (i.e., for all claims lines associated with the APC collectively). Claim lines for services that are not grouped into an APC (e.g., CPT/HCPCS codes with a status indicator of A) were assigned an allowed amount equal to two times the 2017 Medicare allowed amount under OPPS for that CPT/HCPCS code.

For emergency services delivered by a nonparticipating facility, in an inpatient facility setting, the revised allowed amount could not be estimated. This is due to the fact that under the Inpatient Prospective Payment System, the Medicare allowed amount for a given DRG varies by hospital. The appropriate information needed to determine the Medicare allowed amount for

these inpatient facility claims was not included on the claims information provided by the carriers (i.e., the rendering inpatient facility was not identified). Therefore, emergency services delivered in an inpatient facility setting by non-participating facilities within the Commonwealth could not be directly modeled under this policy option. Instead, the impact (i.e., percent increase or decrease) on these inpatient facility claims for emergency services was assumed to be equal to the average increase/decrease that resulted from the modeling for emergency services delivered within an emergency department for non-participating facilities, for the same health carrier within that same region.

Finally, we note that Medicare does not allow for a separate payment to be made for services delivered within an emergency department under OPPS when an individual is ultimately admitted from the emergency department. However, when evaluating this policy option, if an individual was admitted to the hospital from the emergency department it was assumed that a payment would still be made for the facility services provided while in the emergency department, and that the amount of the payment would be equal to two times the amount Medicare would have allowed had the individual instead been discharged from the emergency department.

5. Results

In this section we present the results of our analyses, when employing the methodology described in the prior section to the data provided by the health carriers. We modeled the impact on allowed claims under each of the three policy options studied, and present the results by the following categories:

1. The impact on allowed claims for emergency services that were delivered by non-participating health care professionals within the Commonwealth, in total, and separately for the following six categories of service:
    a. Emergency department visits[1]
    b. All other evaluation and management (E&M) services[2]
    c. Surgical procedures[3]
    d. Anesthesia services[4]
    e. Physical medicine[5]
    f. All other emergency services
2. The impact on allowed claims for emergency services that were delivered by non-participating facilities within the Commonwealth
3. The impact on allowed claims for all medical and prescription drug services covered under the comprehensive health insurance policies

The impact on paid claims cannot be modeled without re-adjudicating each claim based on the underlying benefits, which represents an enormous amount of work and was outside the scope of our analyses. However, we expect that the impact on paid claims, and therefore the impact on premiums, would be similar to the impact on allowed claims described in item three above.

HB 1714

The following table presents the modeled impact on allowed claims for emergency services that were delivered by non-participating health care professionals and facilities within the Commonwealth, assuming HB 1714 were enacted. We present the overall average for each category of service, along with the impact on the region with the lowest impact and the region with the highest impact for that category of service, for services provided by health care professionals. While the region that represents the one with the lowest/highest impact for each

[1] Defined as claims containing CPT codes in the range 99281-99288

[2] Defined as claims containing CPT codes in the range 99201-99499, excluding 99281-99288

[3] Defined as claims containing CPT codes in the range 10021-69990

[4] Defined as claims containing CPT codes in the range 00100-01999

[5] Defined as claims containing CPT codes in the range 90281-99199

category of service is the same for all services that fall into that row, a different region may represent the lowest/highest impact for each row. When estimating the overall impact on all allowed claims for emergency services that were delivered by non-participating providers within the Commonwealth (the last set of rows in the table below) the column for the lowest regional impact utilizes the scenario where fair market value for facility services is 25% higher than the allowed amount currently present on the claim record and the column for the highest regional impact utilizes the scenario where fair market value for facility services is 45% higher than the allowed amount currently present on the claim record. For the total rows, the lowest/highest impacts were based on calculating the impact across all services for each region, and selecting the region with the lowest/highest overall impact.

			HB 1714 Average Impact on Allowed Costs		
Provider Type	**Category of Service**	**Percent of Claims[1]**	**Overall**	**Lowest Region**	**Highest Region**
Professional	Emergency Department Visits	17.0%	13%	1%	75%
Professional	Other E&M Services	7.1%	19%	6%	23%
Professional	Surgical Procedures	7.0%	40%	11%	55%
Professional	Anesthesia Services	3.3%	120%	42%	333%
Professional	Physical Medicine	2.3%	24%	5%	32%
Professional	All Other Emergency Services	1.4%	21%	13%	27%
Professional		38.1%	30%	6%	45%
Facility	FMV (25% Incr. to Allowed)	61.9%	25%	25%	25%
Facility	FMV (45% Incr. to Allowed)	61.9%	45%	45%	45%
Total	FMV (25% Incr. to Allowed)	100.0%	27%	21%	
Total	FMV (45% Incr. to Allowed)	100.0%	39%		45%

[1] Represents the percent of all claims for emergency services delivered by non-participating providers within the Commonwealth

The following table presents the modeled impact on allowed claims for all medical and prescription drug services covered under comprehensive health insurance policies, assuming HB 1714 were to be enacted. Based on the results, enactment of HB 1714 could be expected to increase overall allowed costs by approximately +0.1% on average, varying by region from +0.0% to +0.3%.

			HB 1714 Average Impact on Allowed Costs			
			FMV = +25%		FMV = +45%	
Provider Type	**Category of Service**	**Percent of Claims**	**Overall**	**Lowest Region**	**Overall**	**Highest Region**
Professional	Non-Par Emergency[1]	0.1%	29.6%	6.0%	29.6%	44.5%
Facility	Non-Par Emergency[1]	0.2%	25.0%	25.0%	45.0%	45.0%
All	All Other	99.7%	0.0%	0.0%	0.0%	0.0%
Total		**100.0%**	**0.1%**	**0.0%**	**0.1%**	**0.3%**

[1] Represents all claims for emergency services delivered by non-participating providers within the Commonwealth

HB 2544

The following table presents the modeled impact on allowed claims for emergency services that were delivered by non-participating health care professionals and facilities within the Commonwealth, assuming HB 2544 were to be enacted. We present the overall average for each category of services, along with the impact on the region with the lowest impact and the region with the highest impact for that category of service, for services provided by health care professionals. While the region that represents the one with the lowest/highest impact for each category of service is the same for all services that fall into that row, a different region may represent the lowest/highest impact for each row. For the total row, the lowest/highest impact was based on calculating the impact across all services for each region, and selecting the region with the lowest/highest overall impact.

We present the results for the two scenarios that we modeled. The first table below presents the results when making the assumption that the current allowed amount represents the health carrier's median negotiated rate with participating providers for the same emergency service among all of its participating providers. The second table below presents the results when making the assumption that the current allowed amount represents the health carrier's UCR amount for the same emergency service.

Current Allowed Equals Median Negotiated Rate			HB 2544 Average Impact on Allowed Costs		
Provider Type	**Category of Service**	**Percent of Claims[1]**	**Overall**	**Lowest Region**	**Highest Region**
Professional	Emergency Department Visits	17.0%	-45.3%	-66.0%	21.6%
Professional	Other E&M Services	7.1%	-7.5%	-37.3%	8.4%
Professional	Surgical Procedures	7.0%	-33.4%	-40.8%	-3.7%
Professional	Anesthesia Services	3.3%	-24.1%	-52.7%	49.3%
Professional	Physical Medicine	2.3%	-20.1%	-38.8%	16.8%
Professional	All Other Emergency Services	1.4%	-30.3%	-47.2%	-2.7%
Professional	All	38.1%	-32.1%	-52.8%	-14.6%
Facility	All	61.9%	25.5%	-20.6%	177.0%
Total	All	100.0%	3.6%	-35.6%	108.0%

Current Allowed Equals UCR			HB 2544 Average Impact on Allowed Costs		
Provider Type	**Category of Service**	**Percent of Claims[1]**	**Overall**	**Lowest Region**	**Highest Region**
Professional	Emergency Department Visits	17.0%	7.0%	0.9%	42.3%
Professional	Other E&M Services	7.1%	16.9%	7.7%	23.0%
Professional	Surgical Procedures	7.0%	13.2%	8.9%	24.3%
Professional	Anesthesia Services	3.3%	29.8%	8.3%	78.0%
Professional	Physical Medicine	2.3%	15.1%	3.4%	33.8%
Professional	All Other Emergency Services	1.4%	12.2%	8.7%	21.6%
Professional	All	38.1%	12.7%	4.7%	18.9%
Facility	All	61.9%	54.3%	15.1%	187.3%
Total	All	100.0%	38.5%	12.6%	126.6%

[1] Represents the percent of all claims for emergency services delivered by non-participating providers within the Commonwealth

The following observations can be made from the tables above:

- The modeled overall average impact of HB 2544 on services delivered by non-participating providers varies widely based on whether or not it is assumed that the allowed amount currently present on the claim record represents the health carrier's median negotiated rate with participating providers or whether it represents the health carrier's UCR amount. While it is unknown which of these values is currently represented on the claim, given it is common for health carriers to set their UCR at levels close to the 75th or 80th percentile, we believe the more likely of the two is that the current allowed amount represents a health carrier's UCR amount.
- There is a large difference between the impact on allowed claims for these services for the region with the lowest impact and the region with the highest impact. This regional variation is much more significant for facility claims than it is for claims for services of a health care professional.

The following tables present the modeled impact on allowed claims for all medical and prescription drug services covered under comprehensive health insurance policies, assuming HB 2544 were to be enacted. Again we present the results for the two scenarios that we modeled. Based on the results, enactment of HB 2544 could be expected to increase overall allowed costs by approximately +0.0% to +0.1% on average, ranging by scenario and region from -0.2% to +0.4%.

Current Allowed Equals Median Negotiated Rate			HB 2544 Average Impact on Allowed Costs		
Provider Type	**Category of Service**	**Percent of Claims**	**Overall**	**Lowest Region**	**Highest Region**
Professional	Non-Par Emergency[1]	0.1%	-32.1%	-52.8%	-14.6%
Facility	Non-Par Emergency[1]	0.2%	25.5%	-20.6%	177.0%
All	All Other	99.7%	0.0%	0.0%	0.0%
Total		**100.0%**	**0.0%**	**-0.2%**	**0.3%**

Current Allowed Equals UCR			HB 2544 Average Impact on Allowed Costs		
Provider Type	**Category of Service**	**Percent of Claims**	**Overall**	**Lowest Region**	**Highest Region**
Professional	Non-Par Emergency[1]	0.1%	12.7%	4.7%	18.9%
Facility	Non-Par Emergency[1]	0.2%	54.3%	15.1%	187.3%
All	All Other	99.7%	0.0%	0.0%	0.0%
Total		**100.0%**	**0.1%**	**0.0%**	**0.4%**

[1] Represents all claims for emergency services delivered by non-participating providers within the Commonwealth

Additional Proposal - 200 Percent of Medicare

The following table presents the modeled impact on allowed claims for emergency services that were delivered by non-participating health care professionals and facilities within the Commonwealth, assuming this proposal was enacted. We present the overall average for each category of services, along with the impact on the region with the lowest impact and the region with the highest impact for that category of service, for services provided by health care professionals. While the region that represents the one with the lowest/highest impact for each category of service is the same for all services that fall into that row, a different region may represent the lowest/highest impact for each row. For the total row, the lowest/highest impact was based on calculating the impact across all services for each region, and selecting the region with the lowest/highest overall impact.

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			200% OF Medicare Average Impact on Allowed Costs		
Provider Type	**Category of Service**	**Percent of Claims[1]**	**Overall**	**Lowest Region**	**Highest Region**
Professional	Emergency Department Visits	17.0%	-42.5%	-62.4%	11.3%
Professional	Other E&M Services	7.1%	45.3%	7.7%	73.8%
Professional	Surgical Procedures	7.0%	5.0%	-3.0%	73.3%
Professional	Anesthesia Services	3.3%	-45.9%	-60.6%	8.4%
Professional	Physical Medicine	2.3%	9.7%	7.2%	45.5%
Professional	All Other Emergency Services	1.4%	30.9%	3.5%	99.8%
Professional	All	38.1%	-11.9%	-39.4%	32.1%
Facility	All	61.9%	-24.4%	-69.9%	115.8%
Total	All	100.0%	-19.7%	-56.9%	67.2%

[1] Represents the percent of all claims for emergency services delivered by non-participating providers within the Commonwealth

The following observations can be made from the table above:

- The impact of reimbursing emergency services delivered by non-participating providers within the Commonwealth at 200% of Medicare is expected to lead to a change in allowed costs of -11.9% for services delivered by health care professionals and -24.4% for services delivered by facilities.
- Within the set of services delivered by health care professionals, professionals providing services for emergency department visits and anesthesia services could be expected to observe significant reductions in overall allowed cost (-42.5% and -45.9% reductions, respectively), while professionals providing other categories of emergency services could be expected to observe an increase in allowed costs.
- This policy option could result in a significantly different impact by region, with the region modeled to experience the lowest overall impact potentially experiencing an average change in allowed costs of -56.9% and the region modeled to experience the highest overall impact potentially experiencing an average change in allowed costs of +67.2%. The variation by region is much larger for facility services than for services of a health care professional.

The following table presents the modeled impact on allowed claims for all medical and prescription drug services covered under comprehensive health insurance policies, assuming this proposal was enacted. Based on the results, enactment of this proposal could be expected to decrease overall allowed costs by approximately -0.1% on average, ranging by region from -0.4% to +0.2%.

			200% of Medicare Average Impact on Allowed Costs		
Provider Type	**Category of Service**	**Percent of Claims**	**Overall**	**Lowest Region**	**Highest Region**
Professional	Non-Par Emergency[1]	0.1%	-11.9%	-39.4%	32.1%
Facility	Non-Par Emergency[1]	0.2%	-24.4%	-69.9%	115.8%
All	All Other	99.7%	0.0%	0.0%	0.0%
Total		**100.0%**	**-0.1%**	**-0.4%**	**0.2%**

[1] Represents all claims for emergency services delivered by non-participating providers within the Commonwealth

6. Network Participation

The information that could be provided to help the Bureau in assessing the potential impact on provider networks is very limited given the information available (e.g., information is not available at the network or provider level, it is not known what the UCR amount is that would apply to a claim for a participating provider if that provider had instead been non-participating, etc.). It is expected that what is determined as the payment standard under the three policy options studied would have a significantly lesser impact on network participation decisions made by facilities than it would on network participation decisions made by health care professionals.

In many cases, individuals can choose the facility at which they seek services for non-life threatening emergency services. This is not necessarily the case for emergency services delivered by health care professionals they may encounter while being treated at a participating facility. Additionally, a facility will be less likely to terminate its network participation agreement as a result of the policy options studied in this report as the impact of any potential increase in reimbursement for emergency services may be very small relative to the adverse financial impact that could result from becoming a non-participating provider for all other facility services. Therefore, we have limited our analysis in this section to only services provided by health care professionals.

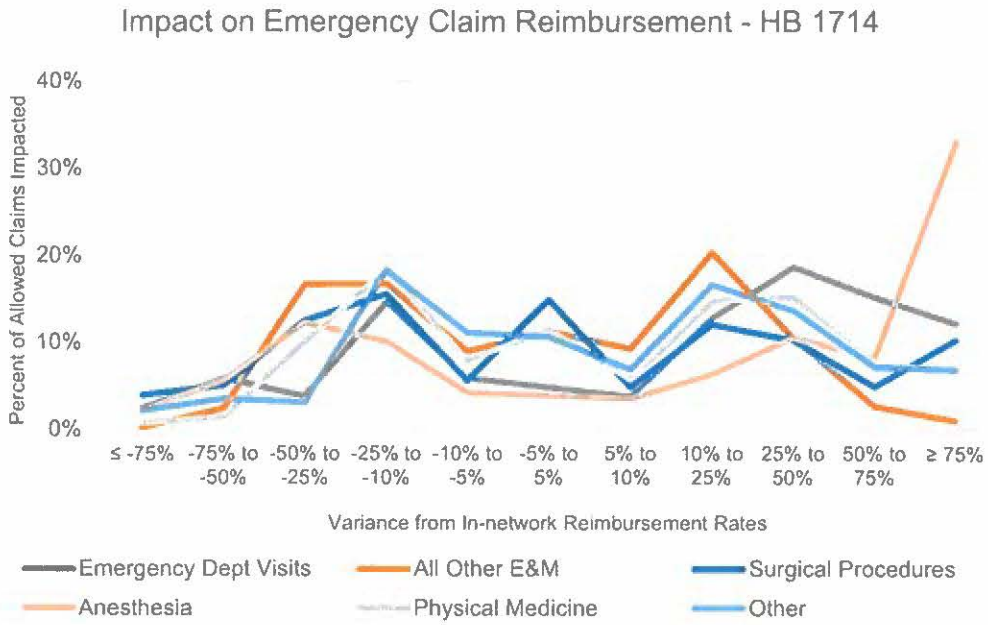
To assist the Bureau and other key stakeholders in assessing the potential impact that these policy options could have on network participation, we conducted a high-level analysis to compare the allowed charges on claims for emergency services delivered by participating providers with the reimbursement they could instead receive as a non-participating provider, under each of the three policy options. We note that the applicable benchmark reimbursement amounts under HB 1714 and HB 2544 are the greatest of several items listed in the draft Bills, however, it is not possible to discern from adjudicated claims for participating providers what the values for a health carrier's median amount negotiated with in-network providers or UCR amount might be. Therefore, our analyses were limited to a comparison of the allowed amounts present on claims for emergency services delivered by participating providers and the regional averages applicable to these two policy options. For the third option where the benchmark reimbursement amount would be equal to 200% of Medicare, the allowed amounts present on the claims were compared to an estimate of reimbursement equal to 200% of the 2017 Medicare allowed amount.

For purposes of these analyses, emergency services were assigned one of six categories based on the CPT/HCPCS code recorded on each claim line, consistent with the categories used to present the results in the prior section. For the claims within each category that represent emergency services delivered by participating providers, the allowed amount recorded on the claim line was compared to either the applicable regional average (for HB 1714 and HB 2544) or 200% of Medicare. The charts below present the results for each of the three policy options studied. The x-axis in each graph represents the expected impact on allowed claims, and the y-axis shows the percent of total allowed claims for that type of service that would be expected to have the stated impact on reimbursement.

HB 1714

As previously discussed, under HB 1714, the regional average for each CPT/HCPCS code is defined as the straight average of the median allowed amounts for each health carrier offering coverage within the region. The nature of using the straight average, as opposed to a weighted average, of the medians results in a wider spread of changes; across all six categories of service, only about 22% of claim dollars are associated with claims where the current allowed amount is within plus-or-minus 10% of the calculated regional average of the medians. The chart shows the distribution of the difference between the allowed amounts currently on claims and the applicable calculated regional average of the medians.

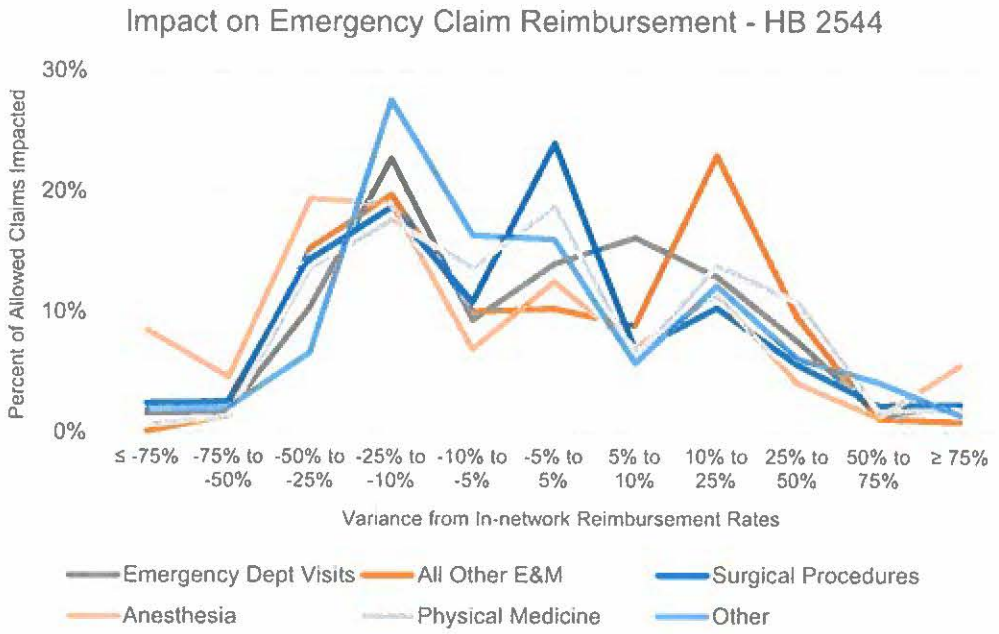
For example, over 30% of claims (as measured by allowed costs) for emergency anesthesia services delivered by participating providers would be expected to realize an increase in the allowed amount of more than 75%, and roughly 50% of claims (as measured by allowed costs) would be expected to realize an increase in the allowed amount of more than 25%. Likewise, roughly 35% of claims (as measured by allowed costs) for emergency department visits delivered by participating providers would be expected to realize an increase in the allowed amount of more than 25% over current levels.



HB 2544

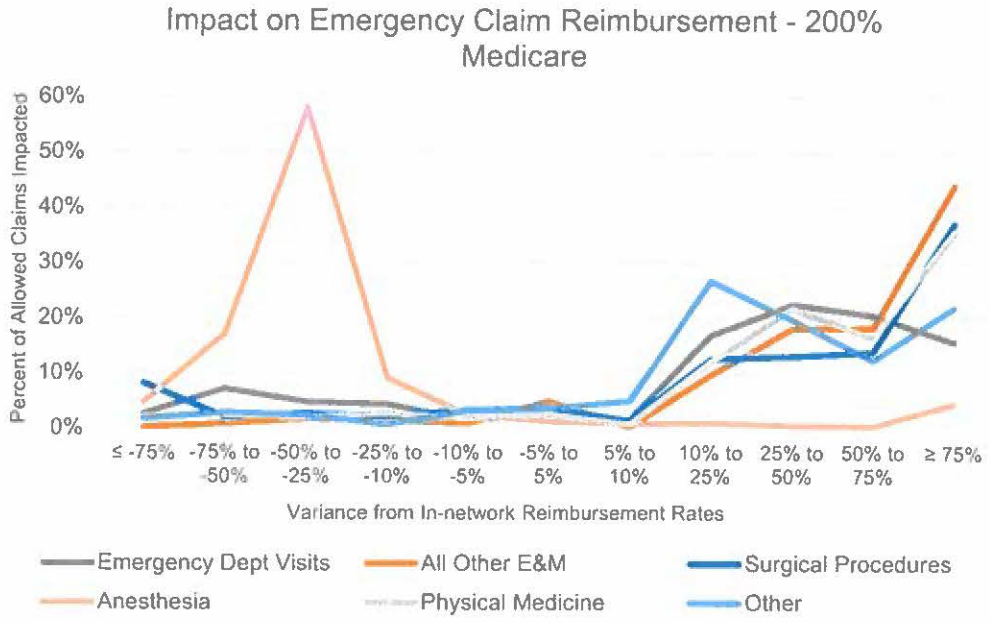
Under HB 2544, the regional average for a given CPT/HCPCS code is representative of the average allowed amount per service for emergency services delivered by a participating provider, for each health carrier and region. Due to the calculated regional average representing an average of the carrier's own contracted rates with participating providers in the region, the impact tends to be fairly uniform with the impacts more concentrated around 0% than for HB

1714, with about half of the emergency services delivered by a participating provider being associated with claims where the provider would experience a decrease in reimbursement and about half being associated with an increase, should the provider cease to be a participating provider. Across all six categories of service, the current allowed amount for emergency services delivered by participating providers for approximately 36% of claims (as measured by allowed costs) is within plus-or-minus 10% of the calculated regional average for the carrier.



Additional Proposal – 200 Percent of Medicare

Under this proposal, in which the amount that a non-participating provider would be required to accept as payment in full would be equal to 200% of Medicare, most participating providers would be expected to experience an increase in their reimbursement relative to current levels, should the provider cease to be a participating provider. In other words, the current contracted rates with participating providers are generally below 200% of Medicare for most categories of service. The exception is anesthesiologists, who are currently being reimbursed more than 200% of Medicare, and would experience a decrease in reimbursement if they were to instead be reimbursed at 200% of Medicare. Across all six categories of service, the current allowed amount for non-participating providers on only approximately 7% of claims (as measured by allowed costs) is within plus-or-minus 10% of 200% of Medicare.


Impact on Emergency Claim Reimbursement - 200% Medicare
Percent of Allowed Claims Impacted
60%
50%
40%
30%
20%
10%
0%
≤ -75%
-75% to -50%
-50% to -25%
-25% to -10%
-10% to -5%
-5% to 5%
5% to 10%
10% to 25%
25% to 50%
50% to 75%
≥ 75%
Variance from In-network Reimbursement Rates
Emergency Dept Visits
All Other E&M
Surgical Procedures
Anesthesia
Physical Medicine
Other

7. Distribution and Use

This report was prepared for the sole use of the Bureau. All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the Bureau. Oliver Wyman's consent to any distribution of this report (whether herein or in the written agreement pursuant to which we issued this report) to parties other than the Bureau does not constitute advice by Oliver Wyman to any such third parties. Any distribution to third parties shall be solely for informational purposes and, in the case of regulators and officers of the State, for purposes of fulfilling related regulatory, administrative, and official functions. Oliver Wyman assumes no liability related to third party use of this report or any actions taken or decisions made as a consequence of the results, advice, or recommendations set forth herein. This report should not replace the due diligence on behalf of any such third party.

8. Considerations and Limitations

Data Verification – For our analysis, we relied on data and information provided by carriers offering commercial health insurance in the Commonwealth of Virginia without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. Our review of data may not always reveal imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions might therefore be unreliable.

Unanticipated Changes – We developed our estimates from historical experience, without adjustments for anticipated changes. Unless otherwise stated, our estimates make no provision for the emergence of new types of risks not sufficiently represented in the historical data on which we relied or which are not yet quantifiable.

Internal / External Changes – The sources of uncertainty affecting our estimates are numerous and include items such as changes in provider reimbursement and claims adjudication practices. The most significant external influences include, but are not limited to, changes in the legal, social, or regulatory environment, and the potential for emerging diseases. Uncontrollable factors such as general economic conditions also contribute to the variability.

Appendix A. HB 1714

2019 SESSION

HOUSE SUBSTITUTE

19105052D

HOUSE BILL NO. 1714
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Commerce and Labor
on January 31, 2019)
(Patron Prior to Substitute—Delegate Ware)

A BILL to amend and reenact §§ 38.2-3438 and 38.2-3445 of the Code of Virginia, relating to health insurance; payment to out-of-network providers; emergency services.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3438 and 38.2-3445 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3438. Definitions.

As used this article, unless the context requires a different meaning:

"Child" means a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child or any other child eligible for coverage under the health benefit plan.

"Codes" has the same meaning ascribed to the term in § 65.2-605.

"Cost-sharing requirement" means a deductible, copayment amount, or coinsurance rate.

"Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual covered by a health benefit plan.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract, or plan covering the eligible employee.

"Emergency medical condition" means, *regardless of the final diagnosis rendered to a covered person,* a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" means with respect to an emergency medical condition: (i) a medical screening examination as required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd (e)(3)) to stabilize the patient.

"ERISA" means the Employee Retirement Income Security Act of 1974.

"Essential health benefits" include the following general categories and the items and services covered within the categories in accordance with regulations issued pursuant to the PPACA: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) laboratory services; (v) maternity and newborn care; (vi) mental health and substance abuse disorder services, including behavioral health treatment; (vii) pediatric services, including oral and vision care; (viii) prescription drugs; (ix) preventive and wellness services and chronic disease management; and (x) rehabilitative and habilitative services and devices.

"Facility" means an institution providing health care related services or a health care setting, including but not limited to hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

"Fair market value" means the price that is determined on the basis of the amounts billed to and the amounts accepted from health carriers or managed care plans by similar providers for comparable out-of-network emergency services in the community where the services are rendered, including amounts accepted under single case agreements, emergency-only participation agreements, and rental network agreements. Fair market value determinations do not include amounts accepted by providers for patients covered by Medicare or Medicaid.

"Genetic information" means, with respect to an individual, information about: (i) the individual's genetic tests; (ii) the genetic tests of the individual's family members; (iii) the manifestation of a disease or disorder in family members of the individual; or (iv) any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by the individual or any family member of the individual. "Genetic information" does not include information about the sex or age of any individual. As used in this definition, "family member" includes a first-degree, second-degree,

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third-degree, or fourth-degree relative of a covered person.

"Genetic services" means (i) a genetic test; (ii) genetic counseling, including obtaining, interpreting, or assessing genetic information; or (iii) genetic education.

"Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. "Genetic test" does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition.

"Grandfathered plan" means coverage provided by a health carrier to (i) a small employer on March 23, 2010, or (ii) an individual that was enrolled on March 23, 2010, including any extension of coverage to an individual who becomes a dependent of a grandfathered enrollee after March 23, 2010, for as long as such plan maintains that status in accordance with federal law.

"Group health insurance coverage" means health insurance coverage offered in connection with a group health benefit plan.

"Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the extent that the plan provides medical care within the meaning of § 733(a) of ERISA to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

"Health care provider" or "provider" means a health care professional or facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Health maintenance organization" means a person licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.).

"Health status-related factor" means any of the following factors: health status; medical condition, including physical and mental illnesses; claims experience; receipt of health care services; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; disability; or any other health status-related factor as determined by federal regulation.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association, or other discretionary group that is not an employer plan, but does not include coverage defined as "excepted benefits" in § 38.2-3431 or short-term limited duration insurance. Student health insurance coverage shall be considered a type of individual health insurance coverage.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Network" means the group of participating providers providing services to a managed care plan.

"Nonprofit data services organization" means the nonprofit organization with which the Commissioner of Health negotiates and enters into contracts or agreements for the compilation, storage, analysis, and evaluation of data submitted by health care providers pursuant to § 32.1-276.4.

"Open enrollment" means, with respect to individual health insurance coverage, the period of time during which any individual has the opportunity to apply for coverage under a health benefit plan offered by a health carrier and must be accepted for coverage under the plan without regard to a preexisting condition exclusion.

"Out-of-network services" means services rendered to a covered person by a health care provider that does not have an in-network participation agreement with the health carrier or managed care plan that governs reimbursement of such services.

"Participating health care professional" means a health care professional who, under contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payments, other than ~~coinsurance, copayments, or~~

~~deductibles~~ *cost-sharing requirements*, directly or indirectly from the health carrier.

"PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further amended.

"Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition was present before the effective date of coverage, or if the coverage is denied, the date of denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage. "Preexisting condition exclusion" also includes a condition identified as a result of a pre-enrollment questionnaire or physical examination given to an individual, or review of medical records relating to the pre-enrollment period.

"Premium" means all moneys paid by an employer, eligible employee, or covered person as a condition of coverage from a health carrier, including fees and other contributions associated with the health benefit plan.

"Primary care health care professional" means a health care professional designated by a covered person to supervise, coordinate, or provide initial care or continuing care to the covered person and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Regional average for commercial payments" means the fixed price, based on data submitted by data suppliers in 2017 pursuant to subdivisions B 1 and 2 of § 32.1-276.7:1 and reported to the Commission's Bureau of Insurance by the nonprofit data services organization, that is determined on the basis of the amounts paid to and the amounts accepted by health care providers, from health carriers by category of providers for comparable out-of-network emergency services, identified by codes, in the community where the services were rendered, including amounts accepted under single case agreements, emergency-only participation agreements, and rental network agreements. Regional average for commercial payments determinations do not include amounts accepted by providers for patients covered by Medicare, TRICARE, or Medicaid. The regional average for commercial payments value shall be adjusted annually by the Bureau of Insurance in an amount equal to the annual increases for that same period in the United States Average Consumer Price Index (CPI) for medical care for the South region, as published by the Bureau of Labor Statistics of the U.S. Department of Labor.

"Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission" does not include:

1. A cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

2. A cancellation or discontinuance of coverage when the health benefit plan covers active employees and, if applicable, dependents and those covered under continuation coverage provisions, if the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative recordkeeping.

"Stabilize" means with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

"Student health insurance coverage" means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education, as defined by the Higher Education Act of 1965, and a health carrier and provided to students enrolled in that institution of higher education and their dependents, and that does not make health insurance coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education, and does not condition eligibility for health insurance coverage on any health status-related factor related to a student or a dependent of the student.

"Wellness program" means a program offered by an employer that is designed to promote health or prevent disease.

§ 38.2-3445. Patient access to emergency services.

A. Notwithstanding any provision of § 38.2-3407.11*,* *or* 38.2-4312.3*,* or any other section of this title to the contrary, if a health carrier providing individual or group health insurance coverage provides any benefits with respect to services in an emergency department of a hospital, the health carrier shall provide coverage for emergency services:

1. Without the need for any prior authorization determination, regardless of whether the emergency services are provided on an in-network or out-of-network basis;

2. Without regard to *the final diagnosis rendered to the covered person or* whether the health care

provider furnishing the emergency services is a participating health care provider with respect to such services;

3. If such services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to such services received from an in-network provider;

4. If such services are provided out-of-network, any cost-sharing requirement ~~expressed as copayment amount or coinsurance rate~~ cannot exceed the cost-sharing requirement that would apply if such services were provided in-network. ~~However, an individual may be required to pay the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay under this section~~ *A covered person shall not be required to pay an out-of-network provider any amount other than the cost-sharing requirement.* The health carrier complies with this requirement if the health carrier provides benefits with respect to an emergency service in an amount equal to the greatest of (i) the amount negotiated with in-network providers for the emergency service, or, if more than one amount is negotiated, the median of these amounts; (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, such as the usual, customary, and reasonable amount; ~~and~~ (iii) the amount that would be paid under Medicare for the emergency service; *and (iv) if out-of-network services are provided (a) by a health care professional, the regional average for commercial payments for such service, or (b) by a facility, the fair market value for such services. The health carrier shall pay any amount due the health care provider pursuant to this subdivision directly, less any cost-sharing requirement.*

A deductible may be imposed with respect to out-of-network emergency services only as a part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum shall apply to out-of-network emergency services; and

5. Without regard to any term or condition of such coverage other than the exclusion of or coordination of benefits or an affiliation or waiting period.

B. If, after the health care provider receives an explanation of benefits, remittance advice, or similar documentation from a health carrier, the health care provider determines that the amount determined by the health carrier as the appropriate reimbursement for emergency services does not comply with the requirements of subdivision A 4, the health care provider shall notify the health carrier of such determination within 90 days of its determination. The health care provider and the health carrier shall make a good faith effort to reach a resolution on the appropriate amount of reimbursement for the emergency services provided.

C. If a resolution is not reached between the health care provider and the health carrier within 30 days of notification under subsection B, either party may request the Commission to review the disputed reimbursement amount and make a determination as to whether such amount complies with subdivision A 4.

D. Claims presenting common codes for the health carrier may be reviewed together by the Commission.

E. Except as provided in subsections B, C, and D, the Commission shall have no jurisdiction to adjudicate disputes arising out of this section.

2. That the nonprofit data services organization (the nonprofit organization) with which the Commissioner of Health negotiates and enters into contracts or agreements for the compilation, storage, analysis, and evaluation of data submitted by health care providers pursuant to § 32.1-276.4 of the Code of Virginia shall submit a report (the report) by July 1, 2019, to the State Corporation Commission's Bureau of Insurance (Bureau) establishing the regional average for commercial payments, as defined in this act, for emergency services. The report shall not identify individual health plans or health care provider-specific reimbursement amounts. Prior to submission of the report to the Bureau, the nonprofit organization shall submit the report to the Virginia All-Payer Claims Database Data Review Committee for review and approval.

3. That any health carrier providing individual or group health insurance coverage shall report to the State Corporation Commission's Bureau of Insurance (the Bureau) no later than September 1, 2019, the number of out-of-network claims for emergency services paid pursuant to subdivision A 4 of § 38.2-3445 of the Code of Virginia as amended by this act in fiscal years 2016, 2017, and 2018. Thereafter, any health carrier providing individual or group health insurance coverage shall report to the Bureau, no later than November 1 of each year, the number of out-of-network claims for emergency services paid pursuant to subdivision A 4 of § 38.2-3445 of the Code of Virginia as amended by this act for the previous fiscal year.

4. That any health carrier providing individual or group health insurance coverage shall report to the State Corporation Commission's Bureau of Insurance no later than September 1 of each year the number and identity of health care providers in the health carrier's network of emergency services providers whose participation in the network was terminated by either the health carrier

or the health care provider in the previous year and, if applicable, whether participation was subsequently reinstituted in the same year. For any terminated health care providers identified by the health carrier in such report, the health carrier shall include (i) a description of the health care provider or health carrier's stated reason for terminating participation and (ii) a description of the nature and extent of differences in payment levels for emergency services prior to termination and after reinstatement, if applicable, including a determination of whether such payment levels after reinstatement were higher or lower than those applied prior to termination.

5. The State Corporation Commission's Bureau of Insurance (the Bureau) shall notify the Chairmen of the House and Senate Committees on Commerce and Labor of the information reported to the Bureau pursuant to the third and fourth enactments of this act no later than December 1 of each year. Such notice shall include (i) the number of out-of-network claims for emergency services paid pursuant to subdivision A 4 of § 38.2-3445 of the Code of Virginia as amended by this act for the previous fiscal year; (ii) the number and identity of health care providers in the health carrier's network of emergency services providers whose participation in the network was terminated by the health carrier or the health care provider in the previous year and whether participation was subsequently reinstituted in the same year; (iii) a summary of the stated reasons for terminating participation; (iv) a summary of the nature and extent of differences in payment levels prior to termination and after reinstatement, if applicable, including a determination of whether such payment levels after reinstatement were higher or lower than those applied prior to termination; and (v) an assessment by the Bureau of the potential impact that any changes in network participation or payment levels for emergency services have had on health insurance premiums in the time period to which the report applies.

HOUSE SUBSTITUTE

HB1714H1

Appendix B. HB 2544

2019 SESSION

INTRODUCED

19103762D

HOUSE BILL NO. 2544
Offered January 9, 2019
Prefiled January 9, 2019

A BILL to amend and reenact § 38.2-3445 of the Code of Virginia, relating to health benefit plans; balance billing for emergency services.

Patrons—Byron, Kory, Robinson and Webert

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3445 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3445. Patient access to emergency services.

Notwithstanding any provision of § 38.2-3407.11, 38.2-4312.3, or any other section of this title to the contrary, if a health carrier providing individual or group health insurance coverage provides any benefits with respect to services in an emergency department of a hospital, the health carrier shall provide coverage for emergency services:

1. Without the need for any prior authorization determination, regardless of whether the emergency services are provided on an in-network or out-of-network basis;

2. Without regard to whether the health care provider furnishing the emergency services is a participating health care provider with respect to such services;

3. If such services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to such services received from an in-network provider;

4. If such services are provided out-of-network, any cost-sharing requirement expressed as copayment amount or coinsurance rate cannot exceed the cost-sharing requirement that would apply if such services were provided in-network. ~~However, an~~ *An* individual ~~may~~ *shall not* be required to pay the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay under this section *for covered services except applicable deductibles, copayment, coinsurance, or other cost-sharing amounts deemed by the health carrier to be non-covered services*. The health carrier complies with this requirement if the health carrier provides benefits with respect to an emergency service in an amount equal to the greatest of (i) the ~~amount negotiated with in-network providers for the emergency service, or if more than one amount is negotiated, the median of these amounts~~ *average of the contracted commercial rates paid by the health carrier for the same emergency service in the geographic region, as defined by the Commission, where the emergency service was provided*; (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, such as the usual, customary, and reasonable amount; and (iii) the amount that would be paid under Medicare for the emergency service.

A deductible may be imposed with respect to out-of-network emergency services only as a part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum shall apply to out-of-network emergency services; and

5. Without regard to any term or condition of such coverage other than the exclusion of or coordination of benefits or an affiliation or waiting period.

6. An out-of-network provider may request the Commission's Bureau of Insurance to determine whether the benefits that the health carrier has determined satisfy its obligation under subdivision 4 do satisfy the carrier's obligation to provide benefits in the amount equal to the greatest of the amounts described in subdivisions (i), (ii), and (iii) of subdivision 4.

INTRODUCED

HB2544

Oliver Wyman
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Milwaukee, WI 53202-4419