America's Health Insurance Plans
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Washington, DC 20004

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Alex Cheng
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Division of Financial Regulation
Oregon Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309-0405

Re: Proposed Rules – Reimbursement Rates for Out-of-Network Providers

Dear Mr. Cheng:

I write today on behalf of America's Health Insurance Plans (AHIP) to provide our comments on the proposed rules implementing SB 1549 and establishing reimbursement rates for health care services provided by out-of-network providers at in-network facilities.

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

We thank the Division for a robust advisory committee process thus far. Looking forward, our members continue to be concerned about the future of out-of-network reimbursement and consumers' costs after the reimbursement structure in SB 1549 and these regulations sunset at the end of 2021. SB 1549 failed to consider the wide variety of factors that can affect how reimbursement rates change over time and instead enacted an automatic, annual inflationary adjustment to reimbursement rates. Over the long term, we again implore the Division to look at more stable options for setting reimbursement of out-of-network providers. Our members in Oregon continue to support a Medicare-based reimbursement as the simplest and most transparent methodology for all parties.

We provide the following comments on the specific requests for public comment and additional concerns from our members:

Geographic Adjustments

Geographic regions need to align with the entire market and should be based on existing claims-based geographic regions. The proposal sets the geographic regions for claims payment based on the geographic rating regions used in the individual & small group market. These markets represent a very small number of claims compared to the total number of claims to which SB 1549 applies. Plans do not currently pay providers according to those seven geographic rating areas, they are solely used for the development of premiums.

Adjusting reimbursement rates based on the Center for Medicare and Medicaid Services' Geographic Price Cost Index (GPCI) is consistent with current claims-paying practices across the nation and would be simpler for health plans and providers to administer. Health plans will have to make major changes to their claims systems to adjust by the proposed geographic rating areas. Furthermore, GPCI is used across the entire commercial market, including the large group market, where the vast majority of the claims are coming from.

CPI Adjustment

We believe that the January 2015 to July 2018 time period chosen in rulemaking most closely reflects the spirit of SB 1549, while also being the simplest to administer. We would reiterate our previous opposition to adjusting the reimbursement formula using the CPI, or any other type of automatic cost inflator, which results in higher and higher reimbursement rates. In the end, the resulting rates will no longer reflects contracted rates, but will distort real market prices, threatening the long-term stability of contracted networks and patient protections.

Since 2009, the CPI adjustment used in these regulations has seen only growth,[1] so this adjustment will, in effect, impose an automatic increase in what plans must pay providers. Once the CPI inflator is applied, this new reimbursement rate will no longer accurately reflect the current allowed amount and will automatically increase costs in the system each year, regardless of the change negotiated in provider contracts over the same period of time.

Health plans manage costs by negotiating with providers to provide services through contracted, high value networks. Annual negotiations may result in an increased reimbursement rate for providers, but that increase does not necessarily equal the CPI. The CPI inflator harms consumers if it creates an environment where there are no incentives to enter into a mutually beneficial provider-health plan contract. It only creates a perverse incentive for providers to remain non-contracted in order to increase their reimbursement. This gaming in the system would automatically increase provider reimbursement based on nothing but a formula-driven increase in health care costs. This does not account for the quality of care provided or what is reflective of true market costs.

In the future, we hope that the Division will advocate for a reimbursement methodology in which no inflationary adjustment is necessary but looks to a formula that is based on actual contracted rates as intended by SB 1549.

Obstetrical Anesthesiology Services

We believe that the proposed regulations adequately accommodate obstetrical anesthesiology services and do not believe that a special formula is needed to address these services. We would

[1] Consumer Price Index for All Urban Consumers, U.S. city average series for all items, not seasonally adjusted, 2008-2018. Available online at https://beta.bls.gov/dataViewer/view/timeseries/CUUR0000SA0.

oppose an effort to treat these services (or anesthesia for any other particular service) differently than all other anesthesia services. If the DFR wishes to add an additional element to this already complicated process, we ask for further discussion about the problem that is occurring with these services to allow all stakeholders to develop a common-sense solution together.

AD Modifier for Anesthesia-Related Procedures

The AD modifiers are to be used when anesthesia services are supervised by a anesthesiologist and more than four concurrent anesthesia procedures are performed. Typically, these services are paid only according to modifier policies of a carrier and Medicare has rules related to such use as well. We do not believe that the AD modifier needs to be used for anesthesia-related procedures in these rules. We believe that the modifiers currently included in the proposed regulations and fee schedule adequately reflect current claims practices. For administrative simplification purposes, we again ask that this already complicated process not be made more complicated.

Missing Base Rates

We ask for clarification that, when a claim does not have a base rate listed on the fee schedule, that a Medicare-based reimbursement be viewed as an acceptable rate of reimbursement for initial payment. This could lead to a further negotiation with the provider as afforded under SB 1549. However, plans need a benchmark rate to pay claims in a timely fashion and cannot cede such claims to a manual person-to-person negotiation each and every time such code is received. We therefore suggest that a plan paying off a Medicare-based reimbursement rate found acceptable by the DFR be acceptable for compliance purposes under these rules.

Enforcement

We also want to reiterate our concerns that, although HB 2339 prohibited balance billing, it contained no oversight or enforcement provisions over providers' activities. We believe that it is critical and important to enact a consumer protection mechanism to oversee providers' billing practices to ensure that they are no longer balance billing enrollees. We hope that the Division will support steps to enforce the prohibition on balance billing or establish authority under another state entity with the power to protect consumers from such illegal billing practices.

Other states have included these types of enforcement mechanisms in their out-of-network billing legislation. California included such enforcement by the Department of Insurance and the Department of Managed Health Care. Likewise, Washington included the following enforcement provisions on providers and facilities in a current proposal that will be debated in the legislature:

- Makes a pattern of violations of the balance billing ban unprofessional conduct for providers.

- If the Commissioner has cause to believe that any provider or facility has engaged in a pattern of unresolved violations of the balance billing ban, allows the Commissioner to submit information to the department of health or the appropriate disciplining authority for action.
- If any provider or facility has engaged in a pattern of violations of the balance billing ban, allows the department of health or the appropriate disciplining authority to levy a fine or cost recovery upon the person and take other action as permitted under the authority of the department or disciplining authority.
- Gives the disciplining authorities the power to levy a fine and take other formal or informal disciplinary action if a potential pattern of violations of the balance billing ban by a provider is substantiated.
- Gives the Insurance Commissioner the power to levy a fine if the Commissioner has cause to believe that a hospital or ambulatory surgical facility has engaged in a pattern of violations of the balance billing ban and take other formal or informal disciplinary action as permitted under the Commissioner's authority.
- Requires the department of health or disciplining authority to review any potential violation submitted by the commissioner or initiated directly by an enrollee and notify the commissioner of the results of the review, including whether the violation was substantiated, and any enforcement action taken as a result of a finding of a substantiated violation.

We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue. If you have any questions, please do not hesitate to contact me at lgassaway@ahip.org or 202-861-6365.

Sincerely,

Leanne Gassaway
Senior Vice President, State Affairs and Policy