Joint Standing Committee on Health Coverage, Insurance and Financial Services

Additional Written Comments

(received after 2:00 pm 4/27/22 and before 9:00 am 4/28/22)

- Gwen Simons, Maine Chapter, APTA
- Kate Ende, Consumers for Affordable Health Care
- Jay Bradshaw, Maine Ambulance Association
- Dan Morin, Maine Medical Association
- Amanda Richards, Maine Osteopathic Association
- Zev Meyerowitz, Cape Integrative Health
- Molly Smith, American Hospital Association

APTA Maine
A Chapter of the American Physical Therapy Association

Testimony to HCIFS Committee on Problems with Anthem BCBS
April 28, 2022

Senator Sanborn, Representative Tepler and Honorable Members of the HCIFS Committee:

My name is Gwen Simons. I am the lobbyist for the Maine Chapter of the American Physical Therapy Association. The Maine APTA represents over 2500 physical therapists (PTs) and physical therapist assistants (PTAs) in Maine.

Thank you for the opportunity to provide testimony today. Unfortunately, 3 minutes is not enough to scratch the surface of the problems PTs are having. The problems range from *slow pay* or *no pay* to ***extraordinarily burdensome pre-authorization requirements*** that are add significant costs for providers. Anthem's monopoly position in Maine also makes them unresponsive to provider complaints.

These problems are making many PTs in private practice contemplate going out of network with Anthem. New private practices are choosing to stay out of network with *all* insurance carriers. This creates great potential for a crisis in access to low-cost care in the future if something isn't done.

MEAPTA has many suggestions for solutions – some which require a legislative remedy. We plan to bring forth legislation to stop the unduly burdensome pre-authorization requirements next year.

We also believe some problems can be more timely resolved by the Bureau of Insurance if the Bureau were more receptive to provider complaints. Historically the Bureau has been dismissive of provider complaints - quoting their policy that they don't get involved in provider-carrier contract disputes. But when the provider is representing the complaints of the patient/consumer and the carrier's conduct violates Maine laws that protect consumers, we believe the Bureau should at least evaluate the facts of the complaint and intervene if it is in the patient's best interest regardless of who the complaint comes from. Patients don't understand these issues enough to know how to complain. That's why the ACA explicitly allows patients to appoint an authorized representative – which may be a provider – to intervene on behalf of the patient in patient-carrier disputes. We would love to work with the new administration at the Bureau to figure out how providers can serve as a patient's authorized representative in complaints without being perceived as asking the Bureau to intervene in provider-carrier contract disputes. We believe that would go a long way to nip some problems in the bud.

If we can help you by providing additional information, please feel free to contact me at gwen@simonsassociateslaw.com or 207-883-7225. Otherwise, we look forward to proposing some legislative solutions in the next legislative session.

Gwen Simons, Esq, PT, OCS, FAAOMPT

Gwen Simons, Esq, PT, OCS, FAAOMPT
Lobbyist, Maine Chapter APTA

Consumers for Affordable Health Care

Advocating the right to quality, affordable health care for all Mainers.

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April 27, 2022

Senator Heather Sanborn, Chair
Representative Denise Tepler, Chair
Members, Joint Standing Committee on
Health Coverage, Insurance and Financial Services

Re: Health insurance carrier provider contracting issues related to Anthem and the potential impact on consumers, the state employee health plan and Maine's health insurance market if Maine Medical Center terminates its provider contract with Anthem.

Senator Sanborn, Representative Tepler, and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services. This letter is to provide information, as requested by the Committee, regarding health insurance carrier provider contracting issues related to Anthem and the potential impact on consumers, the state employee health plan and Maine's health insurance market if Maine Medical Center terminates its provider contract with Anthem.

Consumers for Affordable Health Care is a nonpartisan, nonprofit organization that advocates the right to quality, affordable health care for all people in Maine. CAHC serves as Maine's Health Insurance Consumer Assistance Program which provides toll-free access to certified application counselors who help Mainers understand their health coverage options and how to apply and enroll in private health insurance. In addition to enrolling in coverage, we also help people navigate using their private insurance and how to resolve issues, including helping people challenge coverage denials file private insurance appeals. It is with this experience that we offer the following comments.

Maine Medical Center's recent announcement to leave Anthem's provider network at the end of the year has brought attention to several issues related to insurance carrier/provider contracting and billing practices, as well as rate negotiations. Changes to provider networks are not uncommon, and consumers often bear the brunt of the fallout when a provider is removed from a carrier's network. However, given the size of Maine Medical Center and the Anthem's large market share in Maine's insurance markets, this change has the potential to impact hundreds of thousands of Maine people. The decision to leave a carrier's network, as well as the underlying issues that lead to this decision, also raise important questions about what consumer protections are in place, and whether they are sufficient to ensure people have adequate access to providers, don't experience gaps in care or have treatment plans disrupted, and are not charged excessive prices for medical care or their health insurance coverage.

If Anthem no longer contracts with Maine Medical Center, it will impact consumers differently depending on the type of coverage someone has and what services they need. In some instances,

consumers may be entitled to the same in-network level of coverage for services received at Maine Medical Center. For example, under state and federal law, most out-of-network emergency services must be covered at the same level as if they were provided in-network. In-network coverage may also be available for some types of non-emergency services, when approved by the carrier, such as for certain services or specialty care not offered or reasonably available in-network. However, obtaining approval to go out-of-network for services can be difficult and extremely time consuming and burdensome for consumers, and in some cases may require completing multiple appeals processes over the course of several months.

The difficulty in obtaining coverage for out-of-network services touches on several issues, involving network requirements and the standards used to measure access, as well as the undue burden placed on consumers to prove network inadequacy or lack of sufficient access when navigating carrier utilization review and appeals processes.

According to MRSA 24-A §4303, "carriers shall provide to its members reasonable access to health care services." Maine Medical Center is Maine's largest hospital and the largest tertiary care hospital in Northern New England, which may raise questions about Anthem's ability to provide adequate access to providers and care without MMC. Can Anthem provide its members "reasonable access to health care services" without contracting with MMC? How far is it reasonable to require someone to travel for services? How long is it reasonable to require someone to wait to receive services- a week or two? A month, or longer? What does "reasonable access" mean? We are not claiming one way or the other whether Anthem is able to provide reasonable access without contracting with MMC. However, there aren't clear-cut answers to the questions posed above, which is a problem. There should be clear standards to determine the adequacy of a carrier's provider network and measure reasonable access to care.

Requirements for carriers to maintain an adequate provider network and ensure reasonable access to care vary between different types of services and providers, and in many instances rely on carriers to set their own standards. Under Rule Chapter 850, carriers are required to have, and annually update, an Access Plan with a description of its provider network, including:

> *Written standards for providing a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be reasonably accessible without unreasonable delay. Standards must be realistic for the community, the delivery system, and clinical safety. In establishing these standards, the carrier may incorporate standards published by independent standard-setting organizations and approved by the Superintendent.*[1]

Rule Chapter 850 only provides quantitative standards for certain types of providers and care. Specifically, it requires carriers maintain a minimum ratio of one full-time equivalent primary care provider to 2,000 enrollees, to the extent reasonably possible.[2] This is the only quantitative standard in the rule that sets a specific number or minimum ratio for a type of provider in a health plan's network. It also requires carriers to collect and annually analyze data to measure behavioral health care performance against standards for access to:

a) care for non-life-threatening emergencies within 6 hours;

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[1] Rule Chapter 850 Section 7(A)

[2] Rule Chapter 850 Section 7(B)(1)

b) urgent care within 48 hours; and
c) an appointment for a routine office visit within 10 business days.[3]

For all other types of services and providers, carriers are responsible for establishing their own standards and metrics for the number and geographic distribution of providers and measuring their performance in providing access to services.

It is worth noting that Maine used to have additional quantitative time and distance standards, however these were eliminated under P.L. 90 in 2011. However, several other states currently utilize provider ratios requirements and time and distance standards to determine reasonable access to care. CMS has also proposed time and distance requirements for plans offered on the Federal Marketplace in 2023.[4]

However, measuring reasonable access should go beyond just geographic and timeliness standards. For example, whether a network includes access to a sufficient number of culturally and linguistically competent providers for the members it serves should also be considered. Reasonable access measurements should also consider whether networks include providers specialized in LGBT health care including treatment for gender dysphoria, mental health and substance use disorders, as well as care for serious and chronic diseases, such as cancer treatment, HIV/AIDS, and diabetes, as well as a full range of pediatric providers, including subspecialists and providers that serve children with special needs.

Requiring "reasonable access," in the absence of clear standards, makes it very difficult to consistently enforce due to the ambiguity. It also makes it extremely difficult for consumers to understand what their rights are under their health plan, and to know when they should file an appeal if they are denied coverage for out-of-network services. CAHC has helped many consumers successfully appeal coverage denials based on network adequacy issues. Challenging denials based on network adequacy can be time intensive and may require completing multiple levels of appeals, often spanning several months, before obtaining coverage.

Appealing coverage denials can be extremely difficult and overwhelming for individuals to navigate, especially when experiencing a health care issue, so it is not surprising that most consumers don't appeal denied claims. In fact, a Kaiser Family Foundation analysis of claim denials for health plans available on HealthCare.gov found that consumers only appealed **one-tenth of one percent** of denied in-network claims in 2019. According to the analysis, on average carriers denied 17% of all in-network claims in 2019. In Maine, the average denial rate was slightly higher, at just under 21%. Anthem BCBS of Maine denied over 40% of in-network claims, which was the **third highest denial rate in the country**, among the 112 carriers offering HealthCare.gov plans[5].

Although consumers may request authorization to receive coverage for out-of-network services when services are not available or reasonably accessible from in-network providers, this often

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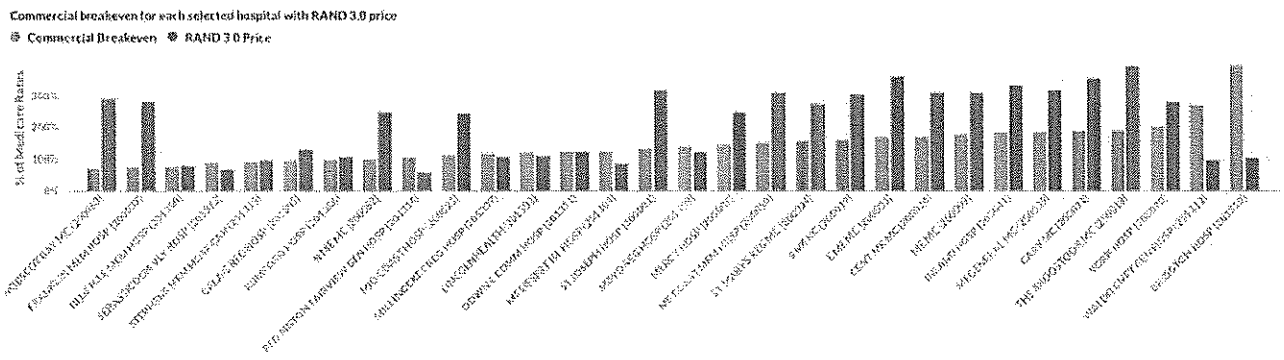
[3] Rule Chapter 850 Section 7(C)(2)
[4] https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/
[5] https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/

requires consumers to navigate cumbersome utilization review and appeals processes, and thus is not a sufficient substitute for an adequate provide network.

While steps should be taken to strengthen consumer protections and increase monitoring of carrier compliance with access standards, there is also a need to address underlying health care costs. If carriers are forced to accept negotiated rates that are excessively high, those costs will get passed down to their members through higher premiums and/or out-of-pocket costs.

Prices for services can vary significantly between hospitals, as well as between payors within a single hospital. Recent federal regulations have helped increase hospital price transparency, however there is little to no oversight to how these prices are set. Maine should, and in fact used to, provide more oversight of hospital prices and cost growth. The National Academy of State Health Policy recently released a new interactive Hospital Cost Tool that provides information and analysis for various metrics to measure hospital profitability and costs. For example, the chart below compares the commercial breakeven point with the RAND 3.0 Price for hospitals in Maine:[6]



Commercial Breakeven Point: Payment level required from commercial payers (expressed as a percentage of Medicare rates) to allow the hospital to cover maximum hospital expenses, with no profit, for hospital inpatient and outpatient services. Covered hospital expenses include commercial patient hospital operating costs, shortfall or overage from public health programs, charity care and uninsured patient hospital costs, Medicare disallowed costs, and hospital other income and expense.

RAND 3.0 Price: Prices paid to hospitals by commercial payers for inpatient and outpatient services, expressed as a percentage of Medicare rates. Prices are calculated based on paid claims from 2016 through 2018 by health plans participating in the 2018 RAND Corporation's Nationwide Evaluation of Health Care Prices Paid by Private Health Plans. Source: https://employerptp.org/rand-3/

As you can see in the above chart, the RAND 3.0 price is significantly higher than the commercial breakeven point for many hospitals in Maine. This means, according to NASHP's analysis, several Maine hospitals are charging insurers significantly more for services than what it costs for the hospital to provide those services, even after accounting for cost-shifting to cover

[6] Source: NASHP Hospital Cost Tool, Maine, 2019. Available at: https://d3g6lgu1zfs2l4.cloudfront.net/

expenses such as free care and uninsured patient costs and any shortfall from public health programs.

Other states have taken steps to address hospital costs. For example, Maryland utilizes an All-Payer Model, which establishes hospital rates.[7] Massachusetts has a Health Policy Commission that is an independent state agency that monitors health care spending growth and provides data-driven policy recommendations.[8] Commercial health care spending growth in Massachusetts has been below the national rate every year since 2013, when the Commission was formed. This has generated billions of dollars in avoided spending.[9] Last year, Maine enacted legislation to establish the Office of Affordable Health Care, which we hope will be helpful in identifying strategies to address cost-drivers and rising and high health care costs in Maine.

Thank you for your consideration. If you have any questions, please don't hesitate to contact me at kende@mainecach.org or 207-480-2136.

Sincerely,

Kate Ende
Policy Director
Consumers for Affordable Health Care

[7] https://hscrc.maryland.gov/pages/rates.aspx
[8] https://www.mass.gov/orgs/massachusetts-health-policy-commission
[9] https://www.commonwealthfund.org/publications/case-study/2020/mar/massachusetts-health-policy-commission-spending-growth

McCarthyReid, Colleen

From: Jay Bradshaw (Maine Ambulance Assoc) <jay@maineambulance.org>
Sent: Wednesday, April 27, 2022 3:00 PM
To: McCarthyReid, Colleen; HCIFS
Cc: Ferdinand, Bill
Subject: Comments on insurance contracts with ambulance services

We would like to begin our comments by thanking both chairs and all committee members for their interest and attention to EMS in general, and the reimbursement challenges faced by Maine's ambulance services in particular.

Following the report from the work group formed during the 129th (LD 2105), this committee introduced LD 1258 to implement the unanimous recommendations of the EMS work group.

That bill, which was unanimously passed in committee and became PL 241 was intended to expand the number of ambulance services who were "in network" with private insurance carriers and as an incentive, this bill established a "standard offer" contract and services were to be offered the ability to be "in network" and paid 200% of Medicare, plus the Medicare add-on for urban, rural, and super rural areas.

The representatives of the insurance industry and private carriers on the committee also all agreed to these recommendations that went into effect on October 1, 2021.

That's where the good news ends.

Since that time, our members are reporting that Anthem and many other carriers in most cases are either refusing to enter into a contract with those terms, or have developed their own creative interpretation of the law, or are simply ignoring ambulance services who contact them altogether.

As the largest private carrier, we have heard this complaint more about Anthem than the other carriers, but it is a message repeated throughout our industry. One carrier (not Anthem) even emailed an ambulance service indicating that since out of network ambulance services were reimbursed at 180% of Medicare, there was no incentive for them to enter into a contract that would cost them 20% more.

Maine's ambulance services are a classic small business literally fighting to keep the lights on and the wheels turning. Ambulance administrators are faced with tremendous staffing challenges and often are simply worn down by the push back or non-response from insurance carriers. To the point where they eventually have to set this aside to manage their essential operation. One can't help but wonder if that's the goal of the private insurance carriers.

As an association, we have struggled with how best to help these services without running afoul of any antitrust laws. We have shared the PL and conducted numerous administrative training sessions on ambulance finance and contracting - and as we hear complaints, we encourage them to reach out to the Bureau of Insurance for assistance.

However, even at the BoI, these small businesses struggle to find meaningful help.

In retrospect, perhaps we were naive as LD 1258 was drafted thinking that the insurance carriers understood the intent and would work as collaboratively with ambulance services in contracting as they had in the LD 2105 work group that drafted the recommendations.

We will continue working with ambulance services and with the work groups established by LD 1258 that have a report due back to HCIFS at the beginning of the next session - and we will use that report to provide an update on contracting and seek additional legislation if needed to get carriers to do that which they agreed.

I would like to close as I began, with our sincere thanks.

Jay

MAINE AMBULANCE ASSOCIATION
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Maine Medical Association

Jeffrey S. Barkin, MD, President | Erik N. Steele, DO, President-Elect | Paul R. Cain, MD, Chair, Board of Directors
Andrew B. MacLean, JD, CEO | Dan Morin, Director of Communications & Government Affairs

April 27, 2022

Via Email:
The Honorable Heather Sanborn, Chair
The Honorable Denise Tepler, Chair
Members, Joint Standing Committee Health Coverage, Insurance & Financial Services
Colleen McCarthy Reid, Esq., Office of Policy and Legal Analysis
colleen.mccarthyreid@legislature.maine.gov

Dear Committee Members:

The Maine Medical Association (MMA) is the state's largest professional physician organization representing more than 4300 physicians, residents, and medical students across all clinical specialties, organizations, and practice settings

Thank you for providing a forum for stakeholder feedback on the recent announcement by Maine Medical Center to terminate its provider contract with Anthem BCBS starting January 2023.

While we appreciate health care payment issues have received greater attention with the recent announcement, the MMA started to receive complaints from smaller independent physician practices earlier in 2021. It's important to note smaller independent physician practices are caught in an extraordinarily unequal bargaining position with large nationwide insurance carriers and the physicians' reliance on Anthem BCBS to provide access to significant portions of their patient base. It's just not a fair fight.

Unfortunately, the Legislature missed a potential opportunity to address the issue this Session when Legislative Council denied an after-deadline bill request by Representative Anne Perry (LR2623) concerning independent providers that were having troubles negotiating with carriers and/or getting paid for services. The bill request apparently would have applied to the Bureau of Insurance by providing a mechanism within the Bureau for providers to obtain direct help with those issues.

Background

In January 2021, Anthem BCBS updated its Provider Data Management System (October 2020 notice attached). Immediately, countless reimbursement claims submitted by independent physician practices were arbitrarily downcoded and payments reduced or withheld in total based solely on a diagnosis code. Anthem BCBS was using a computer algorithm to automatically cut payments for providing important patient care—including critical mental health care with no review of medical necessity, medical facts, or reviews of patient medical records. This new policy placed a huge new administrative burden on these physicians and their staff, as well as a significant loss in practice revenue.

The Explanation of Benefits (EOB) described that a computer program analyzes the claims and based on the diagnosis code determined whether submitted charges were appropriate. The computer algorithm was developed by a company called Cotiviti, and the unilateral downcoding called "Cotiviti edits." To challenge such arbitrary actions, physician practices were required to submit chart notes through an appeals process which often would take over 6 months to reversal, if granted at all.

Most concerning, we were frequently told that individual physicians and practice managers were oftentimes unable to speak directly with the peer reviewers or medical directors supervising the claims process. If practices were lucky enough to reach the medical reviewers and peer reviewers, they were not necessarily trained in the medical specialty for the claims they reviewed.

It is becoming increasingly common that payors downcode certain services provided in emergency departments and other office visits without reviewing records. In the case of Anthem BCBS, they were not sending any pre-notification for the unilateral downcoding from Cotiviti edits. The only communication was a footnote on the Explanation of Benefits (EOB example attached). It shows a downcode claim from CPT code 99214 to 99213, while for another patient, the 99214 paid as a 99214. When the practice attempted to reprocess claims, Anthem BCBS responded with little detail or explanation on the attached Anthem Claims Reprocessing Denial. The practice in question spent hundreds of hours mailing physical copies of every patient interaction more than 1,000 miles to the company's Indianapolis headquarters in an effort to appeal all the downcoded or denied claims.

While suspending the Cotiviti edits adjudication process by Anthem Blue Cross Blue Shield in September 2021 was welcomed news for Maine physician practices, a better step would be a complete and total termination to unilateral claims denials and downcoding. Payers nationwide, and now in Maine are simply assuming providers are guilty of coding all high level of care claims incorrectly and requiring additional steps from the provider to verify the coding or accept a lower payment for the services they provided. The appeals process is onerous, causes costly delays and adds bloat to an already costly health care delivery system. Insurance carriers have established a complex, bureaucratic and time-consuming appeals process for physician practice disputes.

In addition to presumptively downcoding stand-alone traditional evaluation and management codes (E&M 99214 and 99215's), many psychiatric physician practices have experienced underpayment for behavioral health therapy add-on codes. Many Maine psychiatrists have relayed that their practices are existentially threatened by failure to be paid what they are rightfully owed in a timely manner at a time when the shortage of psychiatrists in Maine is near 'crisis levels'.

Physicians select the procedure or service that "accurately identifies" the services performed to reach their final diagnoses. The key components in CPT code selection for the practice of medicine are the extent of history, examination, and medical decision making that was performed. A diagnosis code only represents an endpoint after a thorough evaluation was performed, and in no way can accurately describe the work expended by the physician and their staff. Physician practices under contract with Anthem BCBS should have the opportunity to meet and confer with medical reviewers and medical directors on a case-by-case basis on what's best for the patient, not capitulate to a system that saves insurance companies money by reflexively denying medical care that has been determined necessary by a physician.

Thank you for considering our comments. We urge the 131st Legislature and/or Bureau of Insurance to consider adopting statutory and/or regulatory solutions that will improve transparency, protect patients, and ensure appropriate reimbursement for medical care and prevents insurance companies from arbitrarily downcoding claims or develop and enact policy that prevents downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Relevant Media Coverage

News Center Maine: Anthem Insurance Software Changes Delays Payments To Therapists, Health Care Workers In Maine (Oct 22, 2021)

News Center Maine: Patients Dropped After Mental Health Providers Claim Anthem Reduced Payments (Oct 26, 2021)

News Center Maine: Hundreds of Maine, NH health care providers missing thousands in payments from Anthem (Nov 16, 2021)

Modern Healthcare: AI Does What Insurers Ask. Providers Say That's The Problem. (Jan 18, 2022)

Maine Public: Independent Health Care Providers In Maine Express Frustration With Anthem's Payment Practices (Apr 07, 2022)

Evaluation and management services correct coding - professional

Published: Oct 1, 2020 - **Administrative**

We continue to be dedicated to delivering access to quality care for our members, providing higher value to our customers and helping improve the health of our communities. In an ongoing effort to promote accurate claims processing and payment, we are taking additional steps to assess selected claims for evaluation and management (E/M) services submitted by professional providers. Beginning on January 1, 2021, we will be using an analytic solution to facilitate a review of whether coding on these claims is aligned with national industry coding standards.

Providers should report E/M services in accordance with the American Medical Association (AMA) CPT® manual and CMS guidelines for billing E/M service codes: Documentation Guidelines for Evaluation and Management. The appropriate level of service is based primarily on the documented medical history, examination and medical decision-making. Counseling, coordination of care, the nature of the presenting problem and face-to-face time are considered contributing factors. The coded service should reflect and not exceed that needed to manage the member's condition(s).

Claims will be selected from providers who are identified as coding at a higher E/M level as compared to their peers with similar risk-adjusted members. Prior to payment, we will review the selected E/M claims to determine, in accordance with correct coding requirements and/or reimbursement policy as applicable, whether the E/M code level submitted is higher than the E/M code level supported on the claim. If the E/M code level submitted is higher than the E/M code level supported on the claim, we reserve the right to:

- Deny the claim and request resubmission of the claim with the appropriate E/M level,
- Pend the claim and request documentation supporting the E/M level billed, and/or
- Adjust reimbursement to reflect the lower E/M level supported by the claim.

The maximum level of service for E/M codes will be based on the complexity of the medical decision-making and reimbursed at the supported E/M code level and fee schedule rate.

This initiative will not impact every level four (4) or five (5) E/M claim. Providers whose coding patterns improve and are no longer identified as an outlier are eligible to be removed from the program.

Providers that believe their medical record documentation supports reimbursement for the originally submitted level for the E/M service will be able to follow the dispute resolution process (including submission of such documentation with the dispute).

If you have questions on this program, contact the Provider Call Center.

666-1020-PN-NE

URL: https://providernews.anthem.com/maine/article/evaluation-and-management-services-correct-coding-professional-2

Featured In:
October 2020 Anthem Maine Provider News

00047507040O

01624

Anthem BlueCross BlueShield

[redacted] MD
PROVIDER ID NO: 01Z215471ME02 CHECK/EFT DT: 06/02/21
CHECK/EFT: 0001520775

HMO CHOICE (OA)

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [redacted]				INSURED'S ID: [redacted]					PATIENT NAME: [redacted]				FOR INQUIRIES CALL:
PATIENT ACCOUNT#:				CLAIM NUMBER:					RECEIVED DATE: 05/29/2021				(833) 772-4121
SERVICE PROVIDER NAME: [redacted]				SERVICE PROVIDER ID: 1508091281					EXPL CD:				
NETWORK: IN NETWORK				RELATIONSHIP TO INSURED: SUBSCRIBER					DRG RCVD: N/A				
			Billed 99214	Paid 99213						Reference for downcoding			
05/19/2021 05/19/2021	99214	11	268.00	73.63	0.00	15.00	0.00	194.37	194.37	H08 186	15.00	135 3	58.63
05/19/2021 05/19/2021	90833	11	83.00	13.87	0.00	0.00	0.00	69.13	69.13	066 45	0.00		13.87
	TOTAL:		351.00	87.50	0.00	15.00	0.00	263.50	263.50		15.00		72.50
INTEREST													0.00
	TOTAL NET PAID												72.50

[redacted]

HMO MAINE LOCAL NETWORK

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [redacted]				INSURED'S ID: [redacted]					PATIENT NAME: [redacted]				FOR INQUIRIES CALL:
PATIENT ACCOUNT#:				CLAIM NUMBER:					RECEIVED DATE: 05/29/2021				(833) 772-4121
SERVICE PROVIDER NAME: [redacted]				SERVICE PROVIDER ID: 1508091281					EXPL CD:				
NETWORK: IN NETWORK				RELATIONSHIP TO INSURED: CHILD					DRG RCVD: N/A				
			Billed 99214	Paid 99214									
05/12/2021 05/12/2021	99214	02	268.00	110.26	0.00	0.00	0.00	157.74	157.74	066 45	0.00		110.26
05/12/2021 05/12/2021	90833	02	83.00	42.98	0.00	0.00	0.00	40.02	40.02	066 45	0.00		42.98
	TOTAL:		351.00	153.24	0.00	0.00	0.00	197.76	197.76		0.00		153.24
INTEREST													0.00
	TOTAL NET PAID												153.24

00047507070

01627

Anthem BlueCross BlueShield

[redacted] MD
PROVIDER ID NO: 01Z215471ME02 CHECK/EFT DT: 06/02/21
CHECK/EFT: 0001520775

[redacted]

EXPL CODES	EXPLANATION
135	This is your copay. You may have already paid this at the time of service.
066	This is the amount in excess of the maximum allowed amount for a participating provider. The member, therefore, is not responsible for this amount.
H08	Evaluation and Management procedure code reduced based on diagnostic information. Disputes must include documentation.
H91	Code is considered an add-on. The primary code was denied or missing.
013	Expense occurred after coverage terminated.
038	We applied this amount to your deductible. Your deductible is the amount you pay for health care before we start sharing the costs.
067	This is your share of the cost (coinsurance).
959	We divided your copay among the different services you received during your doctor/facility visit.
3	CO-PAYMENT AMOUNT
45	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL REDUCTIONS) THAT HAVE RESULTED FROM PRIOR PAYER(S) ADJUDICATION.
186	LEVEL OF CARE CHANGE ADJUSTMENT.
B15	THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT, IF PRESENT.
200	EXPENSES INCURRED DURING LAPSE IN COVERAGE
1	DEDUCTIBLE AMOUNT

Anthem
BlueCross BlueShield

Anthem Blue Cross Blue Shield
PO Box 533 North Haven,
CT 06473-0533

[redacted]
PORTLAND, ME 04101-1505

March 24, 2021

Patient's Name:
ID Number:
Service Date:
Claims number:
Charges:

[redacted]

Dear Provider:

Please be advised that we received your inquiry for the claim [redacted]. Upon escalating the claims for code keyed in the system, we received an update with our dedicated escalation team that codes were keyed in correctly, they were purposely processed at a lower level of office visit code per the Cotiviti edit. The original office visit/E&M codes they billed are for a longer session however based on the edit and the condition/dx billed on the claim, a lower level/shorter session of visit is more applicable. This is not a system issue and you will need to send medical records to support the need and usage of a higher level of service.

If you have further questions or concerns, please contact Provider Services at (855 854 1438). You can call (Monday – Friday, 8:00 AM – 5:00 PM).

Sincerely,

Lyn D.
Provider Services

Maine Medical Association

Jeffrey S. Barkin, MD, President | Erik N. Steele, DO, President-Elect | Paul R. Cain, MD, Chair, Board of Directors
Andrew B. MacLean, JD, CEO | Dan Morin, Director of Communications & Government Affairs

April 27, 2022

Via Email:
Colleen McCarthy Reid, Esq., Office of Policy and Legal Analysis
colleen.mccarthyreid@legislature.maine.gov

To: Committee On Health Coverage, Insurance and Financial Services
Fm: Jeffrey Barkin MD, DFAPA President, Maine Medical Association

We have been aware of behavior on the part of the Anthem Insurance Company which has been dangerous to the people of Maine. Beginning last summer, we became aware that the Anthem Insurance Company was unilaterally down coding claims of healthcare providers. This resulted in the providers being paid substantially less – on the order of 75% - than what they would have been paid had their charges been honored. If this were not bad enough, the Anthem Insurance Company did not pay providers for claims submitted and was unable to even process claims as their software did not accept provider's national provider identification numbers (NPIs). Without the capacity to recognize NPI numbers, Anthem was unable to process claims and pay providers. This is their fundamental function, and they were unable to fulfill it.

While all this may sound technical, Maine providers were unable to get paid. This impacted provider of all types. Imagine the solo practitioner who had to turn to a home equity line of credit to keep their practice alive. Imagine the largest hospital in the state – Maine Medical Center – having to separate from Anthem because of nonpayment. Imagine countless other health care providers – ranging from physical therapists to optometrists to physicians of all types and to hospitals – being unpaid by Anthem, the largest insurance company in the state of Maine. Anthem's footprint is tremendous as they cover many of the State of Maine employees and 300,000 of our neighbors.

Anthem's behavior of denying claims has made it so that Maine healthcare providers have had to leave the Anthem network. This has led to patients being unable to have their insurance accepted by these providers. While providers continue to be willing, ready, and able to care for our patients, being unpaid by the insurance company simply shifts the financial burden to the patients. Anthem policy holders are responsible for payment when the providers leave the Anthem network. Nobody can practice for free and continue to offer critical services.

The ability to remain healthy and be treated is important to all Mainer's. It is safe to say that health care is a critical pillar of our economy, employing one in five Mainers. Health care is an ecosystem that impacts us all and safety is paramount. Health care is like the airlines industry in that even the smallest deviation from procedure can lead to catastrophic consequences. We would not want to have our family member get on an airplane that doesn't function correctly; the behavior of Anthem in denying claims and putting our health care system at risk is of similar magnitude.

The current crisis with Anthem not paying claims and taking it upon themselves to underpay providers of all types creates an opportunity that should not be missed. Specifically, several changes should be considered which would rapidly encourage Anthem and other insurance companies to not practice dangerous behaviors. Specifically, we encourage:

1. The legislature empowers the Bureau of Insurance to more front and center consider the health care needs of the people of Maine. The Bureau of Insurance has been a conduit between the insurance companies, including Anthem, and the providers. However, missing from this equation are the patients of Maine. It is important that the legislature find creative ways to compel the Bureau of Insurance to represent the interests of the patients of the State of Maine and not merely adjudicate issues pertaining to providers and payors.

2. In medicine, we practice according to evidence-based best practices. This is an opportunity for to demand the use of best practices by the health insurance and payor community. It is also an opportunity to identify worst practices that must be avoided. We strongly encourage the legislature to delineate specific and explicit practices which would more robustly hold insurance companies to predefined and agreed upon goals such as paying claims on time, avoiding unilateral down coding, or other obstructive processes that are dangerous to providers and the people of Maine. Simply put, the current crisis with Anthem provides an opportunity to do better.

In the event that Anthem and other insurance companies are unable to change their behavior, we will see the increase in alternative practice and delivery models including direct primary care, internet-based delivery systems, and the increased emergence of not-for-profit third-party administrators that can perform the essential administrative functions of commercial payors such as Anthem at much less cost.

The Maine Medical Association remains poised to work as a convener and help facilitate a process with the payors and providers to work together to identify these best and worst practices. It is our hope that by explicitly defining and codifying best and worst practices we can prevent a recurrence of the present situation we find ourselves in with Anthem.

To: Maine Legislature - Committee on Health Coverage, Insurance and Financial Services

Date: April 28, 2022

Re: Testimony on Billing Issues Related to Anthem Blue Cross Blue Shield of Maine

To: Senator Sanborn, Representative Tepler and Honorable Members of the HCIFS committee.

My name is Zev Myerowitz, and I am the Director of Health Services at Cape Integrative Health (CIH), a multi-specialty group located in Cape Elizabeth, ME where I additionally reside. CIH offers primary care, physical therapy, chiropractic, and acupuncture services. We have been in operation for 10 years and CIH performs over 30,000 office visits annually. I additionally serve as vice-president of the Maine Chiropractic Association.

Almost 1 year ago to the week I was digitally testifying on this exact issue: Anthem's abuse of Pre-Payment Review as a vehicle to deny payment for usual and customary services. The Committee *unanimously* voted in favor of approving LD 1317 after learning about Anthem's arbitrary and capricious denials, inconsistent practices, and abuse of the contractual obligations small businesses are strong-armed to endure.

Despite the passing of LD 1317, Anthem continues these hostile business practices. Indeed, they have pushed inappropriate bundling and denials so far that even Maine's single largest hospital system, with all of their coding and administrate resources, has thrown their hands up and will no longer serve these patients. I'm aware of dozens of small business health practices such as ours that have pulled out of network with Anthem. Due to our location and patient population, pulling out of the Anthem network would effectively mean no longer taking any insurance. This would be a significant financial blow to our current patient population. If we find that other self-funded employer groups, such as the Maine Municipal Association or Maine Education Association, follow MaineHealth's suit and drop Anthem as their plan administrator, then we will pull out of network without hesitation.

When I testified before you 1 year ago, Anthem related accounts receivables measured approximately half of our annual gross receipts. In 1 year we have only been able to recuperate half of that amount. No small business can thrive when an insurer holds an entire quarter's worth of revenue in purgatory. I ask this committee to encourage the Bureau of Insurance to utilize its fully powers under state law to ensure patient care is appropriately paid for.

Respectfully Submitted,

Zev Myerowitz Jr. D.C., MS., L.Ac.

Director: Health Services

Cape Integrative Health

McCarthyReid, Colleen

From: Smith, Molly <mollysmith@aha.org>
Sent: Wednesday, April 27, 2022 2:25 PM
To: McCarthyReid, Colleen
Subject: HCIFS Committee Meeting on April 28/AHA Written Materials Submission
Attachments: AHA ASHP Letter to FDA on White Bagging-3-31-21.pdf; AHA Letter to Anthem Coverage and Payment Policies.pdf; AHA Letter to Anthem PHE Response.pdf; AHA Letter to Congress on Insurers Accountability During PHE-10-15-2020.pdf; GA Anthem Consent Order (1).pdf; IN Business Journal_Anthem Dispute.pdf

Dear Ms. McCarthy Reid:

Thank you to the Committee for holding tomorrow's session on Maine Medical Center and Anthem. I have registered my intent to provide public comment at the meeting. In addition, I would like to provide the following written documents to supplement my comments:

- American Hospital Association (AHA) letter to Anthem from Sept. 2021 regarding AHA concerns regarding Anthem coverage and payment problems
- AHA letter to Congress on insurer accountability during the public health emergency, including AHA concerns regarding Anthem's emergency services coverage policy
- Joint AHA/American Society of Health System Pharmacists letter to the Food & Drug Administration on risks associated with specialty pharmacy policies
- AHA letter to Anthem in Apr. 2020 regarding assistance to hospitals during the public health emergency
- GA Insurance Department Consent Order regarding Anthem
- Indiana Business Journal article regarding the mass arbitration regarding Anthem's emergency services coverage policy

Please let me know if I can provide any other information or answer any questions.

Best,
Molly

Molly Smith
Group Vice President, Public Policy
American Hospital Association
800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
202-626-4639
e-mail: mollysmith@aha.org

March 31, 2021

Dr. Janet Woodcock
Acting FDA Commissioner
Food and Drug Administration
10903 New Hampshire Ave
Silver Spring, MD 20903

Re: Request for Meeting – White Bagging and DSCSA

Dear Commissioner Woodcock,

The American Society of Health-System Pharmacists (ASHP) and the American Hospital Association (AHA) are writing to express concern that the payer-mandated drug distribution model, known as "white bagging" is jeopardizing patient safety and exacerbating supply chain security challenges that the Drug Supply Chain Security Act (DSCSA) sought to address.

ASHP represents pharmacists who serve as patient care providers in hospitals, health systems, ambulatory clinics, and other healthcare settings spanning the full spectrum of medication use. The organization's nearly 58,000 members include pharmacists, student pharmacists, and pharmacy technicians. For 79 years, ASHP has been at the forefront of efforts to improve medication use and enhance patient safety. Like ASHP, the top priority of the AHA and its members is to provide high quality, safe health care to all patients, including the safe storage, preparation and administration of critical medications. Representing nearly 5,000 member hospitals, health systems and other health care organizations and clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders belonging to professional membership groups, the AHA is committed to curtailing payer efforts that threaten patient safety and safe medication acquisition processes.

Payers are using white bagging to circumvent hospital supply chain controls by requiring patient medications be distributed through a narrow network of specialty pharmacies that are often directly affiliated with the payer, thereby disregarding DSCSA's requirements for wholesale distribution of drugs. Hospitals and providers are then forced to further manipulate and dispense these medications before they can be safely administered to patients.

White bagging has surged in frequency over the past decade, creating what amounts to a shadow inventory that hospitals and health systems do not legally own and which exists largely outside of the DSCSA's track and trace requirements. A Drug Channels report found that in 2019, nearly a third of infusion drugs (both oncologic and non-oncologic) provided in hospital outpatient departments were distributed via white bagging.[1] Given the growing ubiquity of payer-mandated white bagging, we are concerned that this practice threatens DSCSA's underlying goals. Further, because hospitals do not have legal title to white bagged medications and the drugs are delivered outside of hospital-established supply chains, white bagging can raise additional patient safety risks by enabling diversion and heightening the possibility of drug spoilage/wastage. In addition, as white bagged drugs bypass

[1] https://www.drugchannels.net/2020/09/specialty-pharmacy-keeps-disrupting-buy.html

established supply chain channels it also disrupts and significantly complicates the ability to respond to FDA drug recalls.

ASHP and AHA strongly encourage FDA to consider the patient safety and supply chain security risks of white bagging, and take appropriate enforcement action to protect patients. We would welcome the opportunity to meet with your team to discuss our hospital and health system compliance concerns in greater detail.

We are deeply appreciative of the work FDA staff has put into implementing DSCSA to date, and we recognize the challenge white bagging presents to the overall goals of DSCSA. We look forward to working collaboratively with the Agency to protect against the creation of payer-mandated distribution models that could undermine patient safety. Please do not hesitate to reach out to us, or Mark Howell, AHA Senior Associate Director of Policy at mhowell@aha.org or 202.626.2317, or Tom Kraus, ASHP Vice President of Government Relations at TKraus@ashp.org or 301.664.8605.

Thomas P. Nickels
Executive Vice President
American Hospital Association

Tom Kraus
Vice President of Government Relations
ASHP (American Society of Health-System Pharmacists)

American Hospital Association™

Advancing Health in America

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September 9, 2021

Gail K. Boudreaux
President and Chief Executive Officer
Anthem Blue Cross and Blue Shield
220 Virginia Avenue
Indianapolis, IN 46204

Dear Ms. Boudreaux:

America's hospitals and health systems have deep concerns about several Anthem policies that challenge their ability to care for patients during the COVID-19 global pandemic. We call on Anthem to reverse course immediately.

Specifically, our concerns include Anthem's frequent changes to enrollees' coverage, delays in patient care resulting from excessive prior authorization requirements and growing failure to pay claims in a timely manner. Taken together, these issues are creating an untenable situation. Patients are facing greater hurdles to accessing care; clinicians are burning out on unnecessary administrative tasks; and the system is straining to finance the personnel and supplies needed to meet the demands of a surging fourth COVID-19 wave.

Additional details on these issues follow.

UNILATERAL, MID-YEAR CHANGES TO PATIENTS' COVERAGE

Anthem has implemented a number of coverage policy changes during the past 12-18 months that restrict where enrollees can access covered services. Specifically, Anthem, in the middle of an enrollee's plan year, changes where the enrollee may receive a covered service. For example, Anthem may newly require the enrollee to go to an ambulatory surgical center instead of a hospital outpatient department for a certain surgery or require that the enrollee receive a specialty drug furnished by its vendor and not by the treating provider's own pharmacy. These restrictions apply to services provided at *in-network* facilities and, therefore, are confusing for both patients and their providers. In other words, the provider is represented as in-network to the enrollee (for example, the hospital outpatient department); however, Anthem no longer will cover certain services delivered by that provider. Anthem has applied such coverage policy changes to a number of outpatient services, including certain surgeries, imagining and radiology, and specialty pharmacy, among others.

These policy changes raise substantial concerns regarding access, quality and timeliness of care delivery. They also add more complexity to the system for patients. Some of the most concerning examples relate to Anthem's specialty pharmacy policies that require providers to administer drugs to patients provided by an Anthem vendor and not drugs that the providers themselves have acquired and properly stored and handled. Under these policies, cancer patients and others requiring complex, physician-administered drugs like chemotherapy are reliant on an outside vendor to send the necessary drug. If the drug does not arrive on time, or the wrong dose is sent, or the drug was mishandled in route, the provider often cannot proceed with care and must reschedule the patient.

Changes in coverage policies for outpatient surgeries and diagnostic services can have similar effects: Patients are separated from their longstanding providers and delays occur as alternative providers are located. In some cases, Anthem steers the patient toward providers that are unaffiliated with their primary care team, which adds to the complexity of coordinating care for the patient. These delays and the disaggregation of care can have a direct effect on health outcomes.

Anthem introduces these changes in coverage policies throughout the year, and as a result, they amount to a "bait and switch" on consumers. In many cases, an individual or family (or their employer) selected an Anthem plan specifically because of its provider network. However, once they have purchased the coverage, many of those providers are no longer available for certain services.

This convoluted approach to "in-network" care confuses patients and will inevitably increase their out-of-pocket costs. This will occur if the patient either chooses to continue seeing their trusted providers at their own expense or unknowingly accesses a service that is later denied by the plan. We expect many of these patients will receive a surprise bill that is not subject to the patient protections included in the No Surprises Act.

Enrollees should be assured that the policy they bought provides the services and network it promised. We ask that these unilateral, mid-year coverage restrictions stop altogether.

PRIOR AUTHORIZATION COMPLEXITY AND DELAYS

Anthem's application of prior authorization processes has contributed to delays in patient care, excessive burdens on clinicians, and inappropriate denials of medically necessary care. Such processes are now applied to a wide range of services, including those for which there is no evidence of lack of compliance with clinical guidelines, such as post-surgery rehabilitation and cardiac diagnostic services. Adding further complication, authorization requirements vary by line of business. In other words, Anthem often applies different rules depending on whether the patient is in, for example, an individual market plan or a Medicaid managed care plan. Finally, Anthem relies on subcontractors, such as AIM Specialty Health, to manage these processes, and clinicians often report that they receive different guidance from Anthem and AIM about whether prior authorization applies and the requirements for

making requests. When AIM denies a prior authorization request, the subcontractor directs the provider to Anthem for appeals. At this point, Anthem often requests providers send the exact same documentation already provided to their subcontractor, duplicating an already burdensome process.

We also have significant concerns about emerging reports that Anthem now requires the treating provider to speak with Anthem as part of certain prior authorization requests. While peer-to-peer discussions are not abnormal, requiring that these discussions include the treating physician is not normal. This requires providers to literally leave the patient bedside to get on the phone with Anthem. The call must be made within a narrowly prescribed timeline without regard for whether the treating provider is with patients at that time. As a result, providers often cannot make these calls and authorizations are delayed.

Despite these ongoing problems, Anthem recently expanded its contract with AIM to conduct prior authorization medical necessity and other utilization management reviews for outpatient rehabilitation services. This rollout was done without sufficient warning to clinicians and with inadequate education about the new rules and operational processes. In fact, the web portal did not appear to be fully functional at the time of launch – a number of clinicians reported that the rehabilitation tab either was removed completely or was disabled.

While pre-authorization has its place in the role of a managed care organization, the expansiveness and ever-increasing hurdles in Anthem's processes far surpass what is reasonable. **We call on Anthem to take steps to reduce the burden and complexity leading to patient care delays and clinician burnout.** These include: relaxing prior authorization requirements for services that historically have high rates of approval, e.g., more than 95% of the time; ensuring alignment with subcontractors on prior authorization rules and processes; conducting sufficient provider education in advance of policy changes; eliminating instances of multiple record requests; and eliminating the requirement that the treating provider speak with an Anthem representative.

SUBSTANTIAL CLAIMS ADJUDICATION DELAYS

Hospitals and health systems across the country are reporting substantial delays in Anthem's adjudication of claims. One health system reports more than $102 million in Anthem claims have exceeded the prompt payment timeframe allowed in state law. For another health system, delayed payments have reached $148 million. The claims processing delays create financial burdens for patients by forcing them to wait months to receive an explanation of benefits and understand their final out-of-pocket costs. When the patient ultimately does receive their bill it can come as a surprise as so much time has passed. It also creates burden on employers who are not receiving timely notices to fund premiums – leading them to not know their true cost of employee benefits.

We understand these delays are the result of a new claims management system deployed by Anthem earlier this year. The problems appear to include both technical systems issues and errors, such as the incorrect loading of fee schedules. While new systems can have glitches,

the delays in payment have gone on for many months, and despite Anthem's deployment of its "High Abrasion Resolution Team," the delays persist without meaningful improvement. **The financial stress this places on providers could not come at a worse time in light of surging COVID-19 cases and increased costs associated with staffing and supplies to meet the demands of the public health emergency.** Meanwhile, Anthem reported $1.8 billion in income for the second quarter of this year.

All of these policies take us further away from the coordinated, accessible, affordable health care system we envision for our communities. We urge you to take immediate steps to remediate these issues.

Sincerely,

Richard J. Pollack
President and Chief Executive Officer

Cc:

Xavier Becerra, U.S. Department of Health and Human Services
Chiquita Brooks-LaSure, Centers for Medicare & Medicaid Services
Ali Khawar, Employee Benefits Security Administration
Lina Khan, Federal Trade Commission
Richard Powers, U.S. Department of Justice
Tim Wu, National Economic Council

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April 1, 2020

Gail K. Boudreaux
Anthem Blue Cross and Blue Shield
220 Virginia Avenue
Indianapolis, IN 46204

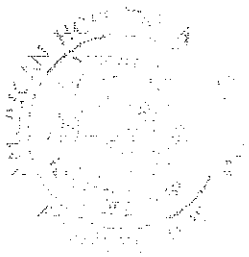
Dear Ms. Boudreaux:

The COVID-19 public health emergency is putting incalculable stress on individuals and families, the economy and the health care system. Addressing this global pandemic requires unprecedented action by everyone. That is why citizens are asked to stay in their homes, businesses are temporarily closed, and health care providers are asked to staff the frontlines despite many challenges. And that is why today America's hospitals and health systems are asking that Anthem join us as we meet this historic challenge to ensure that the health care system is there for anyone who needs care.

This crisis has had an immediate and dramatic impact on health care providers. Elective care is being delayed at the same time that costs are skyrocketing for certain supplies, extra staffing is becoming a critical issue, and hospitals are building surge capacity like never before. This challenge is true for both those hospitals and health systems treating high numbers of COVID-19 patients and those that are not. Inadequate financial resources and cash flow threaten hospitals' ability to remain staffed and open. While Congress and the Administration have taken a number of steps to address these issues, their actions alone cannot fill the gap resulting from reduced revenue from private insurance.

Anthem, as one of the largest health insurers in the United States, could make a significant difference in whether a hospital or health system keeps their doors open during this critical time. The federal government has already taken a number of steps to provide critical resources, such as by providing a bump in reimbursement through the Medicare program for COVID-19 cases and enabling Medicare providers to opt for accelerated payments. However, these actions alone are not enough. We urge private insurers, including Anthem, to commit to similar actions.

Specifically, we ask that insurers support stable cash flow by allowing providers to opt into periodic interim payments and/or accelerated payments for the duration of the public health emergency, much like what is available through the Medicare program. We also ask that insurers eliminate administrative processes that cause delays in payment, such as prior



authorization and certain payment edits, and provide adequate coverage and reimbursement of services in hospitals and alternative sites of care, including by covering cost-sharing for COVID-19 treatment. In addition, we urge insurers to expedite processing of outstanding claims that have resulted in billions of dollars in accounts receivables.

This crisis is challenging for all of us, and everyone has a role to play. The courage and dedication of our front line health care workers who show up every day to care for their communities are an inspiration to us all. We owe them the same kind of dedication by showing up for them. Our patients, our communities and our health care workers deserve nothing less than our best.

Sincerely,

/s/

Richard J. Pollack
President & Chief Executive Officer

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October 23, 2020

The Honorable Frank Pallone Jr.
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Chairwoman, Oversight and
Investigation Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Anna Eshoo
Chairwoman, Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Pallone, Chairwoman Eshoo and Chairwoman DeGette:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks the U.S. House of Representatives Committee on Energy and Commerce for its oversight of certain health insurer practices during the COVID-19 public health crisis. We applaud your recent request to nine health and dental insurance companies for information on their business performance during the COVID-19 pandemic and look forward to your analysis of their responses.

In support of your efforts, we would like to share information regarding the challenges hospitals and health systems have encountered with insurance plans during this unprecedented health crisis. In addition, we offer feedback on the Department of Health and Human Services' COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program.

OVERVIEW

The COVID-19 pandemic has placed considerable stress on communities and the health care providers who care for them. While not every region has experienced the same level of infection, all communities have prepared to respond to the virus. For hospitals, this has meant increasing the capacity to care for patients with COVID-19, as well as supporting federal, state and local public health efforts to track and prevent its spread. All hospitals, whether in communities hard hit by the virus or not, have suffered significant reductions in revenue during this time as both emergent and non-emergent

care has drastically declined and the cost for preparing for the pandemic has been substantial.

For health plans, the impact has been far different. When insurers priced their 2020 premiums, they had no way of knowing that a global pandemic would occur. As COVID-19 began to spread across the country, so did concerns among insurers about a flood of emergency care and high-cost intensive care unit visits. However, as businesses shuttered and governments called on people to stay at home and ordered health care providers to halt most non-emergent care, spending on health care claims declined dramatically.

In fact, many health insurers are not spending nearly as much on care as they anticipated when they set their 2020 premiums. Some of their anticipated expenses have been forgone altogether, in part due to a decrease in more typical health hazards, such as car accidents and pollution-related illnesses. Other expenses may be postponed to a future date, such as preventive services like mammography and colonoscopy screenings. As a result, actuarial firm Milliman estimates that there could be a net reduction of health care costs of $75 billion to $575 billion nationally in 2020. While the costs to test and treat COVID-19 may be significant, Milliman found that "the deferral and elimination of care is a far more impactful driver of costs."

Many analysts and health plans alike believe the pandemic will be financially positive for the health insurance industry. An AHA analysis of various filings by the Securities and Exchange Commission found that the top seven health insurers (in terms of covered lives) reported nearly $12 billion in income before taxes for the first quarter of 2020, representing an 8.3% increase over the previous year. In the second quarter, operating income before taxes jumped to $22.2 billion, which was more than these companies made in the entire second half of 2019. Unsurprisingly, Moody's Investor Services, a credit rating agency, projects that even under the most severe scenarios, health insurers generally have significant capital and liquidity. In contrast, recent AHA reports found that the immense financial strain facing hospitals and health systems due to COVID-19 will continue through at least the end of 2020 with patient volume expected to remain well below baseline levels. Total losses for the nation's hospitals and health systems are projected to be at least $323.1 billion in 2020.

Despite the health care system's financial struggles, some health insurers are treating this excess revenue like they would under normal circumstances: using it to engage in stock buyback; paying down debt; and stockpiling excess premium dollars into their reserves. However, these times are anything but "business as usual," and these dollars are needed to keep our health care system solvent.

As Sean Nicholson and David Asch argue in the Harvard Business Review, insurers "potentially face a windfall because the high clinical costs of caring for infected patients is almost certainly more than offset by the reduced costs from other care foregone. Those extra funds shouldn't be theirs; they were there for our health care, and our

health care system needs them now." **To be clear – taxpayer, employer and individual consumer revenue that health insurers took under the promise of paying for health care services has in many instances been diverted to increase the health insurers' profits.**

The only thing that appears to be reining in insurers' profit opportunity are the medical loss ratio (MLR) rules that require that certain types of health plans spend 80% or 85% (depending on the product) of the premium dollar on health care services. As a result of the MLR rules, some health plan products have begun to issue consumer rebates. However, a significant portion of health plans are not subject to the MLR rules, and it is unclear that these rebates, which are diluted across millions of consumers, will have as much impact as if they were invested in the health care system. As researchers at Georgetown University's Health Policy Institute recently noted: "We are in the midst of the largest global pandemic of our lifetimes. A few hundred dollars in premium relief or rebate checks that won't arrive until the Fall of 2021 will not help us meet the needs of the moment. Instead, policymakers should consider taking advantage of insurers' excess cash to support our underfunded public health infrastructure so that we can effectively bring this virus to heel."[1]

Meanwhile, HHS' COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program is falling short. The Health Resources and Services Administration (HRSA), which oversees the program, adopted rules that make a high percentage of COVID-19 claims ineligible for reimbursement. In fact, these rules specifically exclude some of the most costly cases of COVID-19, leaving the uninsured vulnerable and providers without adequate resources to care for these patients.

Below, we explore each of these challenges and provide specific recommendations to ensure more comprehensive coverage of COVID-19 testing and treatment.

INSURER ACTIONS DURING THE PANDEMIC

While health insurers have benefited from an overall reduction in health care utilization, they continue to pursue other strategies to boost their earnings during this public health crisis. Indeed, a number of health insurer tactics put in place before COVID-19 have financially aided the plans during this time, and several health insurers have even taken steps to expand such policies during the pandemic. These include denials for emergency services, denials for early sepsis interventions, questionable reporting requirements, and abuse of utilization management tools to delay and deny payment.

Emergency Services Denials

Several insurers, such as Anthem, have been denying coverage of emergency services if the health insurer unilaterally determines that the condition did not warrant

[1] http://chirblog.org/insurers-sit-extra-cash-premium-relief-mlr-rebates-best-use-funds/.

emergency-level care. The plan makes its determination after the care is delivered, not based on what the clinician knew at the time the patient presented to the emergency department (ED). This policy was purportedly implemented to discourage inappropriate use of the ED, a goal hospitals and health systems share. However, it has instead been used as a blunt tool that has generated fear among patients of accessing emergency services and resulted in financial losses for providers. Meanwhile, it is unclear these health plans have undertaken even minimal efforts to address barriers to care that could lead to someone seeking non-emergent care in an ED, such as working with primary and urgent care providers to extend hours or ensuring greater access to same-day appointments. These plans also completely ignore hospitals' responsibilities under the Emergency Medical Treatment and Labor Act (EMTALA) to assess and stabilize anyone who presents to the ED, as well as federal law that established prudent layperson standards, which require that the need for emergency services be evaluated based on what an average "prudent" person deems an emergency.

It is unacceptable to discourage anyone from seeking care they believe they need, but it is absolutely unconscionable to do so during a public health crisis. Anthem, for example, has lobbied to expand policies that would discourage some of the most vulnerable residents from obtaining emergency medical care in public programs, and, even in the midst of COVID-19, it has not changed course. This plan continues to support efforts by the Commonwealth of Virginia to permit them to apply this policy for the state's Medicaid managed care plan.

Sepsis Denials

Several insurers, led by UnitedHealthcare, have unilaterally stopped reimbursing providers for the care necessary to treat certain cases of sepsis occurring in inpatients. Specifically, these insurers are choosing to no longer follow the "Sepsis 2" guidelines, which had until now been nearly universally adopted, including by the Centers for Medicare & Medicaid Services for Medicare purposes. Instead, they have unilaterally decided to apply a different standard for identifying sepsis for purposes of reimbursement only. They have begun using newer guidelines, referred to as "Sepsis 3," which were developed specifically for research purposes and focus on identifying only the most severe forms of sepsis. To be clear, the insurers do not intend for providers to change how they clinically treat patients. If a provider determines that a patient has sepsis, they should treat the patient accordingly. The insurers, however, will not necessarily account for that care when reimbursing the provider. Instead, providers are expected to absorb those costs even though the insurer has an obligation to cover this medically necessary care.

This policy risks reducing the quality of care, negatively affects quality improvement efforts and underpays providers. The benefit accrues only to the insurer; it is purely financial, not clinical. This policy is egregious in normal times. However, it is a particular affront to patients and their providers in the midst of a global pandemic for which sepsis is a common corollary condition. These insurers' failure to adequately compensate providers for necessary care jeopardizes providers' ability to care for their patients, and

the fact that insurers have adopted these policies without consultation from providers and outside of standard negotiations is additional evidence of the power insurers wield in negotiations with providers.

Lab Code Reporting

UnitedHealthcare, the largest commercial insurer in the country, has launched new reporting requirements on many of its network laboratories during the pandemic, including certain hospital-based laboratories that are already stressed by the significant demand for COVID-19 testing. These new requirements are questionable in value, in violation of HIPAA transaction standards, and extremely burdensome for hospitals. Specifically, the insurer is requiring as a condition of payment that these laboratories report their unique, organization-specific lab codes, as well as a number of other data points that may or may not exist, such as identifying a lab director for each test and including lab test availability dates. The insurer has failed to provide an adequate rationale for this requirement; however, it appears that it intends to use this data to try to isolate tests that generally are included in panels (e.g., a lipid panel that consists of multiple tests) so that it can do line-item denials of tests within a panel. This policy has no clinical objectives, and will not improve the quality of care. Instead, it appears to be another attempt by an insurer to reduce its spend on covered medical services by questioning physicians' orders.

This is not a trivial ask and ignores the longstanding national standard for coding tests for purposes of reimbursement. The vast majority of lab tests (we estimate between 90% - 95%) have their own Current Procedural Terminology (CPT) code, leaving very few tests that are parts of panels where the panel – and not the individual test – is assigned the CPT code. Requesting these unique codes for each of the thousands of lab services therefore gets no new information for the health plan. Yet, the burden on labs will be immense. The information that is being requested is not usually housed in a single database and cannot simply be downloaded into a spreadsheet, as the insurer has suggested. In fact, the data system vendors that hospitals contract with to manage this information will need to rework their systems to accommodate this requirement, and, if not automated, hospital billing departments will be forced to manually insert information into claims. The financial and time resources to comply will be considerable. One member estimated that it will require at least one half of a full time employee's time to accommodate this requirement and the mandatory future updates.

Testing remains one of the core strategies to fight the COVID-19 pandemic. Laboratories across the country have had to scale up operations and are working around the clock to do their part. To have a health insurer force a laboratory to divert resources to submit unnecessary data at this (or any) time is unacceptable. It is particularly egregious that the insurer would threaten reimbursement if a lab in unable to comply when many providers are struggling financially as a result of the pandemic and health insurer profits are at an all-time high.

Administrative Tactics to Delay and Deny Payment

Many commercial health insurers are eroding coverage by restricting access to health care services through the abuse of utilization management programs and changes in health plan rules mid-year. Tactics include unjustified use of prior authorization, mid-year implementation of "site of service" policies that restrict patient access to in-network providers, failure to pay on outstanding claims resulting in large accounts receivable, and adjudicating medical necessity after a service has been provided and not by relying on the information available to the ordering clinician at the time a patient was seen.

Prior authorization, for example, was designed to help patients obtain the right care in the right care setting. Prior authorization can help ensure that providers order care that is consistent with clinical guidelines and protocols, as well as to confirm that such care is covered by the patient's plan. This tool was designed primarily to help guide (and monitor) providers' decision-making regarding treatments that are new, particularly high cost, or that have a history of questionable use. However, some health insurers are now applying prior authorization to a wide range of services, including those for which the treatment protocol has remained the same for decades and there is no evidence of abuse.

Unjustified use of utilization management tools, such as prior authorization, has a number of negative implications for patients and the health care system. Patients are often blindsided by denials and can face unexpected medical bills as a result of insurers' actions. The extensive approval process that physicians and nurses must navigate adds billions of dollars to the health care system and contributes to clinician burnout.[2]

Evidence of the negative impact of these practices is mounting. The Department of Health and Human Services Office of Inspector General (OIG) warned in a September 2018 report that high rates of Medicare Advantage health plan payment denials and prior authorization delays could negatively affect patients' access to care.[3] In 2019, a federal court found that the largest U.S. commercial insurer was abrogating the *entire point* of health insurance by systematically denying medically necessary, covered behavioral health services for financial reasons.[4]

In response to COVID-19, some health insurers at the urging of government scaled back the use of many of these tactics. State governments, as the primary regulators of insurance, also have taken action. For example, New York State passed a number of insurer accountability measures at the beginning of the COVID-19 to help ensure patient access to care and to remove unnecessary burdens on providers on the front

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[2] Shrank, W. et al., "Waste in the US Health Care System: Estimated Costs and Potential for Savings," JAMA: The Journal of the American Medical Association. October 7, 2019.

[3] U.S. Department of Health and Human Services Office of Inspector General. "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials," OEI-09-16-00410. September 2018.

[4] https://drive.google.com/file/d/1XuzFQV4Z6vClFnpYpTaoS4vBT_RPhQsN/view

lines.[5] However, not all insurers have scaled back the use of these tools, and many insurers that initially reduced these programs have subsequently reinstituted them. In fact, through a recent member survey we learned that some payers have started denying claims for COVID-19 testing citing a lack of prior authorization, despite clear guidelines for when testing is appropriate.

Since early in the crisis, hospitals and health systems have requested assistance from their health insurance partners. The AHA also directly asked the nation's five largest insurers – representing approximately 50% of covered lives – to work with their contract providers to ensure they had the resources necessary to continue to care for patients in their communities. In our April letter, we wrote:

> Insurers could make a significant difference in whether a hospital or health system keeps their doors open during this critical time. The federal government has already taken a number of steps to provide critical resources, such as by providing a bump in reimbursement through the Medicare program for COVID-19 cases and enabling Medicare providers to opt for accelerated payments. However, these actions alone are not enough. We urge you to work with your member organizations to commit to similar actions.
>
> Specifically, we ask that insurers support stable cash flow by allowing providers to opt into periodic interim payments and/or accelerated payments for the duration of the public health emergency, much like what is available through the Medicare program. We also ask that insurers eliminate administrative processes that cause delays in payment, such as prior authorization and certain payment edits, and provide adequate coverage and reimbursement of services in hospitals and alternative sites of care, including by covering cost-sharing for COVID-19 treatment. In addition, we urge insurers to expedite processing of outstanding claims that have resulted in billions of dollars in accounts receivables.
>
> This crisis is challenging for all of us, and everyone has a role to play. The courage and dedication of our front-line health care workers who show up every day to care for their communities are an inspiration to us all. We owe them the same kind of dedication by showing up for them. Our patients, our communities and our health care workers deserve nothing less than our best.

This call to action was largely ignored with one primary exception. Most insurers have waived cost-sharing for COVID-19 care. However, even this promise has not been fully met. Despite the fact that widespread testing is crucial to containing the virus, insurers are increasingly denying payment for tests they deem to be not "medically necessary."

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[5] https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_s01_cl2020_08.

Some hospitals have reported losing in the hundreds of thousands to millions of dollars as a result of denied testing claims. One health system has lost close to $10 million. Treatment denials are even more costly. Hospitals have reported millions of dollars' worth of claims denials for treatment.

In addition, many insurers still have not updated their systems to account for the cost-sharing waivers, and providers have had to override inaccurate information provided by plans to prevent patients from receiving bills for their care. Specifically, when providers run insurance cards for patients, some health insurer systems respond with a positive cost-sharing obligation, not zero, as promised by these health insurers to their enrollees. This inaccurate information is resulting in significant additional administrative burden for hospitals and health systems as they need to reconcile these claims with the insurers. One health system noted that "the variations in the payer interim policies [is] challenging to apply in a standard way" and it is taking a "great deal of resources from the organization to monitor and change" processes regularly. Another commented that "payers have not been consistent with coding and modifier usage and in some cases have changed their stance a number of times which has caused a lot of confusion around billing and also a lot of rework." A number of hospitals and health systems have noted that sorting out these claims not only takes financial and personnel resources, but can delay payments at a time when hospitals are facing immediate cash flow needs. In addition, despite still being deep in the public health crisis, some health insurance cost-sharing waivers are expiring.[6]

HEALTH INSURER ACCOUNTABILITY: ADDITIONAL QUESTIONS FOR CONSIDERATION

We applaud the Committee's focus on the important topic of health insurer practices. In addition to the questions shared with select health insurers on Aug. 13, we believe the following questions will further help the Committee explore this issue.

1. In most markets, health care utilization has declined dramatically. Therefore, providers have fewer resources with which to both maintain capacity to deliver standard services but also stand up capabilities to respond to COVID-19. What actions has your organization taken to ensure that premium dollars paid to your company that were intended for the health care system were shared with providers to help them meet these two objectives?
2. Currently, many health insurance products are undergoing rate review. Please share information on your premium requests for 2021, including the range of changes in premium sought (e.g., -2% in one market to +6% in another), as well as the median and mean requested premium changes. What factors contribute to those requests?

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[6] Kaiser Family Foundation, "Cost-Sharing Waivers and Premium Relief by Private Plans in Response to COVID-19," August 20, 2020. Accessed at: https://www.healthsystemtracker.org/brief/cost-sharing-waivers-and-premium-relief-by-private-plans-in-response-to-covid-19.

3. What percentage of contracted premium revenue have you been unable to collect since Jan. 1? How does this compare with the same period in 2019?
4. Is your company reducing premiums for any of its enrollees? Please provide information on the number of enrollees who are receiving some form of premium reduction, the range of reductions and the total dollar value of premium foregone.
5. Has your company dis-enrolled anyone for non-payment of premiums since Jan. 1? If so, how many total people have you dis-enrolled (count all dis-enrollments even if the individual or employer was subsequently reenrolled)? How does this compare to the same period for 2019?

RECOMMENDED STEPS TO ENSURE INSURANCE PREMIUMS SUPPORT ACCESS TO CARE

Health insurers can take a number of steps to help ensure that hospitals are able to continue serving their communities. While a handful of insurers assisted providers with immediate cash flow problems through accelerated and periodic interim payments, a systematic approach to ensuring premium dollars are spent on health care services would provide more meaningful financial help. First, all insurers should settle existing accounts receivables, which amount to billions of dollars in reimbursements for care that has already been delivered but for which providers still await payment. Second, insurers can help alleviate hospital burden and allow clinicians to focus on the patients who need them. This includes halting certain utilization management practices such as prior authorization, concurrent medical necessity reviews, retrospective reviews and site-of-service denials, all of which direct providers away from patients and contribute to reimbursement denials.

Specifically, we urge the Committee to address the following insurer administrative and payment issues that impose significant burden on hospitals and further strain limited financial resources and apply them to all types of health coverage, including self-funded plans:

- **Expedite accounts receivable:** Require immediate processing of payment for all outstanding claims. Claims under dispute may be paid based on the hospital's or health system's average settlement rate for claims in prior years with a reconciliation process after the end of the public health emergency.

- **Require periodic interim and accelerated payments:** Require health plans, including Medicare Advantage and Medicaid managed care plans, to ensure adequate cash flow for providers by transitioning to biweekly and/or accelerated payments similar to what is available through the Medicare program at a provider's request.

- **Suspend prior authorization, medical necessity, and current and retrospective review:** Suspend these utilization management tools during the public health emergency to remove barriers to care and alleviate burden on providers.

- **Suspend paper processing and edits; extend appeals timeframes:** Suspend other administrative processes, such as audits, any administrative activities requiring paper processing, and certain payment edits that cannot be met while the majority of the workforce is working remotely and consumed with other more immediate COVID-19 related tasks. In addition, extend the timeframe for a hospital to submit an internal or external appeal following a notice of adverse determination given the same workforce limitations.

- **Prohibit emergency care denials based on retrospective review:** Require that health plans adjudicate medical necessity based on information available at the time of ordering and prohibit denials of emergency and related inpatient hospital services as not medically necessary on retrospective review. This requirement should not be limited to the public health emergency period.

COVERAGE FOR THE UNINSURED

Health care coverage plays an essential role in our public health emergency response. Stopping the spread of communicable disease requires every individual in a community have access to public health information, preventive care, testing and treatment. Health care coverage is a key facilitator of access to these services. And it is not just about keeping an individual healthy, it also is about stopping transmission from one individual to another. In other words, in the face of communicable disease, we are all only as safe as our weakest link.

A major weak link in our public health response to COVID-19 is the high rate of uninsured individuals. Even before the pandemic, approximately 10% of individuals nationally were uninsured and that figure reached nearly 20% in some states. Individuals without health care coverage are less likely to have a routine source of care and are more likely to face financial barriers to care. That means uninsured individuals may avoid testing or treatment because they do not know where to go or out of fear of what the care may cost them, remaining in the community without appropriate safeguards to prevent transmission.

Gaps in coverage also deprive public health experts of an important communication and surveillance vehicle. Health insurers and other coverage programs have mechanisms for getting in touch with their enrollees in ways the government does not: they have their phone numbers, emails and addresses, as well as an established relationship that is based on the sharing of health-related information. Instead of relying on general public service announcements, health insurers and other coverage programs can directly reach enrollees with targeted communications. They also can monitor claims data to assess whether individuals are getting the care they need. For example, health insurers can monitor which enrollees have already received a vaccine and target communications to those who have not.

Health care coverage also is critical for ensuring that the health care system is adequately financed. The growing rate of uninsured, as well as the shift from commercial coverage to Medicaid, is further exacerbating the financial struggles of many providers.

The Administration has established a program to provide coverage for certain COVID-19-related services for uninsured individuals. While we appreciate these efforts, we believe they are inadequate. Limited coverage programs such as the one operated by HRSA do not allow for the full scope of services and communication mechanisms available through comprehensive coverage, and they provide no real certainty of coverage for patients or providers. Case in point: the HRSA program for the uninsured fails to cover a significant portion of COVID-19-related care, including some of the most costly cases.

The HRSA program has several significant limitations. First, it fails to cover cases of COVID-19 treatment where official coding rules require that the COVID-19 diagnosis be placed secondary on the claim. The most common example of this is when the patient has sepsis. Coding rules require that sepsis be listed as the primary diagnosis even when the sepsis is corollary to COVID-19. This also means that care for patients who experience after effects of having COVID-19 may not be covered, such as when a patient experiences COVID-19-related pneumothorax, lung clots, stroke or myocarditis, but the patient is no longer testing as active infection.. Second, HRSA has applied an overly broad definition of coverage to determine who is uninsured. For example, individuals in very limited coverage programs, such as state programs that only cover family planning services, have been deemed to be insured and therefore ineligible despite not having comprehensive coverage and certainly no coverage for COVID-related testing and treatment.

In response to our concerns regarding the placement of the diagnosis, HRSA has stated that it is not providing coding guidance and that standard coding rules do not apply to this program. This ambiguous guidance suggests that providers *may* get reimbursed through the program *if* they alter the coding on their claims (however, we do not read HRSA's guidance as explicitly confirming this). This is problematic. First, providers that follow HRSA's approach for coding COVID-19 claims are at risk of HIPAA violations, or worse yet, a charge of fraud and abuse as federal policy does not generally permit providers to deviate from coding rules for purposes of changing their reimbursement. Second, providers must consistently code claims in order to track them for state and federal reporting and quality improvement purposes. Changing the order of the codes changes the diagnostic-related group to which the claim is assigned, making it far harder to track similar cases. Finally, the lack of clarity regarding the rules will almost undoubtedly result in variation in how providers interpret them, resulting in spotty reimbursement for uninsured patients. **We continue to urge HRSA to align its policy with the nationally recognized coding standards.**

However, as discussed above, making these changes to the HRSA program is inadequate for ensuring coverage for the uninsured. **We urge Congress and the Administration to close remaining gaps in comprehensive coverage.** The following steps could make great strides in expanding enrollment in health care coverage and, by extension, routine access to care:

- **Expand employer subsidies to preserve enrollment.** Many employers experiencing loss of revenue as a result of the economic downturn may choose to reduce benefits as one way to manage expenses. Congress could further help employers maintain benefits by expanding eligibility for employer subsidies for the purposes of preserving enrollment in health coverage during the public health emergency.

- **Provide federal subsidies for COBRA.** The COVID-19 public health emergency has already triggered significant job loss. Many individuals may have the option to maintain their job-based health coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) but find the costs to be prohibitive, especially if they are facing a significant reduction in income, as they are expected to cover the entire cost of the monthly premium. Congress could offset the cost of coverage through COBRA to former employees with a direct subsidy or refundable individual tax credits.

- **Provide full federal match for newly expanding states.** Several million uninsured individuals would likely be eligible for Medicaid if the state in which they lived opted to expand Medicaid. Many of these individuals do not have access to employer-sponsored coverage and are not eligible for subsidies on the Health Insurance Marketplaces because they make too little (less than 100% of the federal poverty limit). Congress should create incentives for the remaining 14 states to expand Medicaid by providing full federal match for the first three years of expansion, regardless of when a state expands.

- **Increase eligibility for federal Marketplace subsidies.** Many lower income individuals neither have access to affordable employer-sponsored coverage nor are eligible for Medicaid or the Marketplaces. Congress could assist these individuals by increasing the eligibility threshold for federal subsidies for coverage through the Health Insurance Marketplaces.

- **Establish a Special Enrollment Period (SEP) for Marketplace coverage.** While individuals who have recently lost employer-based coverage are eligible for an existing SEP, the already uninsured do not have that option. We urge the Administration or Congress to stablish a new SEP specifically for those individuals who were already uninsured and not otherwise eligible for an existing SEP.

- **Prohibit cancelation of coverage for non-payment of premiums.** Insurers may disenroll plan participants from Marketplace coverage if the enrollee is unable to pay their portion of the premium for three months. Given the economic downturn, we

encourage Congress to prohibit insurers from disenrolling anyone from coverage for non-payment of premiums if their inability to pay their premiums is due to COVID-19-related job loss or furlough. Insurers also should be required to continue reimbursing providers for the services delivered to those individuals during this time. This prohibition should extend beyond the Marketplaces and apply to all forms of commercial coverage, including self-insured plans with the insurer bearing the cost of coverage for enrollees in self-funded plans.

CONCLUSION

Thank you again for bringing attention to this important topic. The AHA looks forward to working with the Committee as it continues its review process. We believe it is vitally important for our health care system to be supported in this evolving health care crisis, and we stand ready to assist you.

Please contact me if you have questions, or feel free to have a member of your team contact Robyn Bash, vice president of government relations and public policy operations, at rbash@aha.org.

Sincerely,

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy

OFFICE OF COMMISSIONER OF INSURANCE
STATE OF GEORGIA

IN THE MATTER OF:	)	
	)	**Case Number: 11029362**
BLUE CROSS BLUE SHIELD	)	
HEALTHCARE PLAN OF GA., INC.	)	

CONSENT ORDER

WHEREAS, the Commissioner of Insurance of the State of Georgia ("Commissioner") has the duty to uphold the provisions of the Georgia Insurance Code, codified at O.C.G.A. § 33-1-1 *et seq.*; and

WHEREAS, the Commissioner has caused an examination to be made into the acts, practices, transactions, and course of business engaged in by Blue Cross and Blue Shield of Georgia, Inc., and Blue Cross Blue Shield Healthcare Plan of Georgia., Inc. pursuant to O.C.G.A. § 33-2-11; and

WHEREAS, effective January 1, 2019, Blue Cross and Blue Shield of Georgia, Inc. merged with and into Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., with Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. as the surviving entity (as a result of the merger Blue Cross and Blue Shield of Georgia, Inc. and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. are hereinafter referred to as the "Respondent"). The Respondent's stated purpose of merging the two companies was to eliminate duplicative administrative costs. The transaction was approved by the Department on October 9, 2018 (Case Number 11022585).

WHEREAS, based on the information and documentation received by the Georgia Department of Insurance ("Department") through the course of this examination, the

Commissioner has determined that Respondent has failed to comply with certain provisions of the Georgia Insurance Code; and

WHEREAS, Respondent, after being fully advised of all rights and procedures guaranteed to it under the Georgia Insurance Code, including the right to a hearing as provided by O.C.G.A. §§ 33-2-17 and 33-2-24, now desires to enter into this Consent Order, including the Corrective Action Plan attached hereto as Appendix A and incorporated herein by reference for the purpose of resolving all issues described herein, without the necessity of a hearing, and therefore desires to waive any and all such rights and consents to the terms of this Consent Order and the entry thereof; and

WHEREAS, Respondent enters into this Consent Order without admitting or denying violations of Georgia law in regard to the issues described herein.

NOW THEREFORE, the Commissioner finds the following:

1.

Prior to the merger with Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Blue Cross and Blue Shield of Georgia, Inc. held a Certificate of Authority Number 2000667 to act as a healthcare corporation in the State of Georgia and maintained a business location at 3350 Peachtree Road Northeast, Atlanta, Georgia 30326.

2.

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. holds Certificate of Authority Number 200036, to act as a health maintenance organization in the State of Georgia and maintains a business location at 740 W Peachtree St., Atlanta, Georgia 30308.

3.

The Respondent is ultimately owned and controlled by Anthem, Inc. ("Anthem").

4.

A targeted market conduct examination of Respondent was conducted by representatives of the Department with a scope period January 1, 2015, to September 30, 2021.

5.

The examination included, but was not limited to, a review of the Respondent's internal controls related to the implementation of a provider database system during calendar year 2015, implementation of a replacement provider database system during calendar year 2021 and reporting of claims payment data to the Department pursuant to the Department's Directives 99-EXAM-1 and 13-EXAM-2.

6.

During the course of the examination, the Commissioner found that:

a) In March 2015, Respondent implemented an internally developed provider database system designed to consolidate provider data and to serve as a centralized data repository for all Anthem provider demographic data.

b) Following the implementation of the provider database system, provider complaints made to both the Department and Respondent noticeably increased during calendar years 2015-2018.

c) The most common complained of errors ("processing errors") were from: (1) claims from in-network providers processing as out-of-network, and (2) claims rejecting for unknown reasons.

d) As a result of the noted processing errors, a significant number of claims were impacted by issues involving the Respondent's implementation of the provider database system.

e) Respondent implemented a four-phase remediation plan to address provider complaints and claims processing errors and various corrective measures were deployed between 2015-2020, leading to the implementation of a replacement provider database system.

f) During Respondent's implementation of the replacement provider database system (released in April 2021), Respondent performed significant project, implementation, and testing plans of the new system to ensure that adequate safeguards were taken to avert challenges previously experienced with the old provider database system.

g) During this delay, Respondent continued to experience processing errors that resulted from the implementation of the old provider database system. Respondent failed "to adopt and implement procedures for the prompt investigation and settlement of claims arising under their policies," as required under O.C.G.A. § 33-6-34(3).

h) A test of Respondent's submission of claims data pursuant to Directives 99-EXAM-1 and 13-EXAM-2 determined coding and data errors within Respondent's systems caused incomplete and inaccurate claims data submissions to the Department as noted in claims submitted to the Department for claims timeliness testing. Upon the detection of the errors, Respondent revised its internal process for extracting claims timeliness testing data and submitted corrected reports to the Department in 2019.

i) A test of Respondent's compliance with the claims timeliness requirements of O.C.G.A. § 33-24-59.5(b)(1) and/or (c) determined Respondent was out of compliance for several quarters during the period from 2018 to 2021.

ORDER

NOW THEREFORE, IT IS HEREBY ORDERED BY THE COMMISSIONER and agreed to and consented to by Respondent that:

1.

Pursuant to O.C.G.A. § 33-2-24(g), Respondent shall pay a monetary penalty in the amount of Five Million Dollars ($5,000,000.00) to the Georgia Department of Insurance and as applicable, additional monetary penalty as outlined in Appendix B: Performance Milestones.

2.

Respondent shall adhere to the terms of the Corrective Action Plan attached to this Consent Order as Appendix A. Beginning May 1, 2022, Respondent shall submit a monthly report containing all relevant information demonstrating compliance with the Corrective Action Plan until such time as the Commissioner has rescinded this order or March 31, 2023, whichever is sooner (the "Departmental Supervision Period"). Each report shall be signed by an officer of the Respondent and submitted to the Department within ten (10) business days of the last day of each month.

3.

Respondent shall submit to periodic examinations by a qualified individual or firm of the Department's choosing to examine Respondent's compliance with this agreement, as allowed under O.C.G.A. § 33-2-11(a).

4.

The Single Point of Contact, as described in Appendix A, shall be familiar with the Georgia Insurance Code, the Rules and Regulations of the Georgia Department of Insurance, and the laws of the State of Georgia in order to monitor the day-to-day business practices of the Respondent and to ensure compliance with this Order. Specifically, the Single Point of Contact shall be dedicated to assisting Georgia healthcare providers and facilitating the prompt resolution of any conflicts or disagreements between such providers and Respondent.

5.

Responses and action should be made within fifteen (15) business days of the initial complaints, requests or inquiries filed with the Department.

6.

Respondent will adhere to all Prompt Pay Reporting requirements.

7.

Respondent shall implement strict project management controls including extensive testing for any new functional deployments on provider database systems. All testing should be done considering the size and complexity of its Georgia business. Pursuant to Ga. Comp. R. & Regs. 120-2-80-.04, prior to implementing, deploying, or otherwise subjecting Georgia providers to the use of any new functions or systems, Respondent shall give the Department one hundred and twenty (120) days' advance notice during which time the Department may examine Respondent's implementation plans and related controls. Finally, the Respondent will establish and maintain pre and post command centers to oversee the implementation and resolve any issues discovered with a warranty period of not less than one hundred twenty (120) days for any new functions or systems affecting providers implemented for the Georgia business. Respondent shall maintain all records of any new

functions or systems in accordance with the Company's record retention policy, but not less than two (2) years, and for as long as the new system is maintained.

8.

The complaint system process should be filed with the Department by April 30, 2022.

9.

The Respondent shall not pay any ordinary dividend above One Hundred Million Dollars ($100,000,000) or any other dividends during the Departmental Supervision Period without first obtaining Commissioner approval.

10.

This Consent Order resolves all administrative penalties and sanctions of any kind related to the violations discovered within the scope of the examination for the period from January 1, 2015, through September 30, 2021. If Respondent materially violates any of the terms and conditions specified herein or within the accompanying attachments Appendix A and Appendix B, Respondent shall receive notice of such violation(s) and have a fifteen (15) day period, or other cure period as mutually agreed upon in writing by the Department and Respondent, to cure or mitigate such violation(s). Should the Commissioner then find that such material violation(s) and failure to cure or mitigate such violations(s) have occurred, such violation(s) and failure(s) will be considered a violation of this Consent Order and will subject Respondent to further penalties and sanctions. If a hearing on an order issuing administrative penalties and sanctions is requested by Respondent, the burden of proof shall be on Respondent to show cause as to why the action is not justified.

11.

In consenting to the terms and entry of this Consent Order, Respondent has not waived its rights or defenses to any subsequent claims or proceedings before the Department.

SO ORDERED this 29 of March, 2022.

JOHN F. KING
COMMISSIONER OF INSURANCE
STATE OF GEORGIA

CONSENTED TO BY:

BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GA, INC.

By: Robert H Burke

Title: President - Anthem BCBS GA

Sworn to and subscribed before me this

24th day of March, 2022.

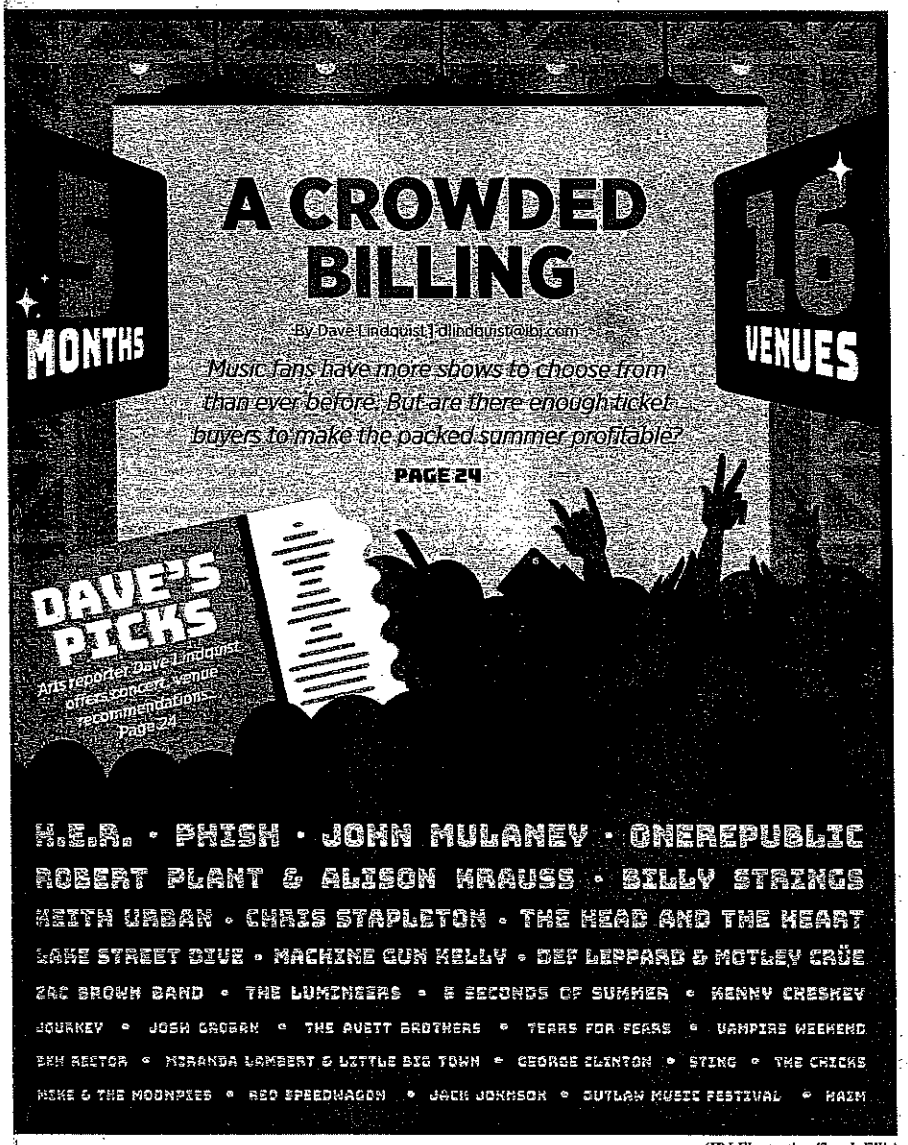
Notary Public

My Commission Expires: 9/17/2023

[Seal] KATHY SHIVER NOTARY PUBLIC COWETA COUNTY, GEORGIA MY COMMISSION EXPIRES SEPTEMBER 17, 2023

17A | Focus
Supply-chain, staffing shortages are dampening the hospitality industry's pandemic recovery.

INDIANAPOLIS | APRIL 15, 2022
BUSINESS JOURNAL
CENTRAL INDIANA'S BUSINESS AUTHORITY



(IBJ Illustration/Sarah Ellis)

Anthem pays $4.5M in ER bill dispute

Hospitals say insurer owes another $12M

By John Russell
jrussell@ibj.com

For five years, health insurer Anthem Inc. has tried to clamp down on what it considered unnecessary, expensive visits to emergency rooms by denying claims or downgrading reimbursements for ER visits that turned out not to be life-threatening.

But now, that policy has come back to bite the Indianapolis-based company.

A group of 11 Indiana hospitals complained that Anthem's policy was unlawful and breached their contracts, costing them millions of dollars. And a federal arbitrator has agreed, ordering Anthem to pay them $4.5 million.

> **"What we've seen over the last three or four years is a gradual, increased use of the emergency room."**
> *Dr. Joseph Fox, Anthem Indiana medical director, in 2017 when its policy changed*

Anthem, which fought the case for two years, says it has complied with the order.

But the hospitals say they can claim at least another $12 million from Anthem for tens of thousands of additional claims that it says Anthem has downgraded and not paid in full. And the count of improperly denied or downgraded claims, they say, is growing by the day.

That matter is still playing out. The arbitrator's ruling says Anthem must stop using a list of diagnostic codes to downgrade and deny the hospitals' claims.

It also has ordered Anthem to pay for all claims that were downgraded, but it did not issue a dollar amount for that set

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Company breaks ground on new HQ.

ANTHEM

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of claims. Anthem has not said whether it will pay additional damages.

The case has thrust into the spotlight the issue of how giant insurance companies decide whether to limit or deny claims for emergency treatment and whether it's proper to use diagnosis codes to determine payment.

For Anthem, it's a setback that some say could reverberate far beyond this group of Indiana hospitals, into other states where the insurer does business.

Lash

"From our perspective, this is a chronic situation with Anthem, not only in Indiana, but in other parts of the country," Alan Lash, a partner at Lash & Goldberg LLP in Miami, Florida, who is representing the hospitals, told IBJ.

What's a proper ER visit?

The case involves contracts Anthem held with hospitals to cover Medicaid patients.

The insurer used a system called AutoPay which identified ER claims and matched them to approved diagnosis codes.

For claims that didn't match approved codes, Anthem downgraded the claim to a "triage fee," usually between $50 and $70, and asked the hospitals to submit additional medical records for review.

The hospitals said Anthem's practice adversely impacted between 60% and 70% of the thousands of ER claims submitted between January 2017 and May 2020, and was unlawful, as hospitals are required to treat all patients who request emergency service, at least to the point of stabilizing their injuries or conditions.

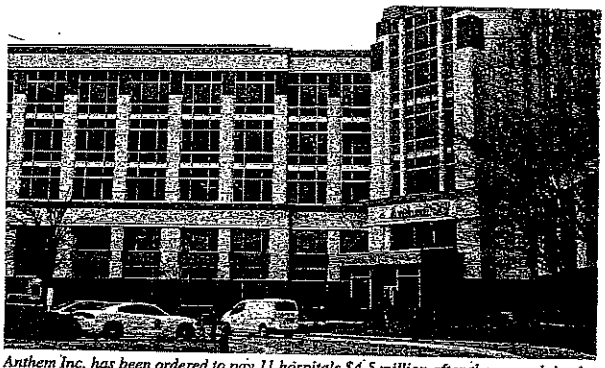
Anthem initially declined to answer questions from IBJ about the case and asked two separate courts to seal all arbitration and contract records on the matter.

Arbitration awards are not typically made public. In this case, however, the hospitals attached the arbitration rulings as exhibits in a filing in U.S. District Court on March 25 and in Marion County Superior Court on April 10.

IBJ obtained records on the dispute from the Marion County Superior Court online docket. As of Wednesday, the court had not acted on Anthem's request to seal the records.

Based on those documents, IBJ posed a list of questions to Anthem. In response, the insurance company acknowledged the dispute concerned "a policy intended to deter the inappropriate use of the ER for non-emergencies."

"Anthem's use of the policy, namely the AutoPay list, was specifically approved and authorized by the state of Indiana to identify ER claims that do not need to be reviewed any further for appropriateness of services," Anthem said in its statement. "Anthem is required by the state to use the same list the state and the other Medicaid managed care organizations use to expedite these payments without further review. The AutoPay list facilitates faster payment of claims, not claim denials."



Anthem Inc. has been ordered to pay 11 hospitals $4.5 million after they complained about it denying claims or downgrading reimbursements for ER visits. (IBJ file photo)

Are chest pains an emergency?

But as far as the hospitals are concerned, the use of diagnosis codes to determine reimbursement is fraught with complications.

They say a patient's decision to go to the emergency room is often complex. For example, a person having chest pains during the day might call a primary doctor or go to a walk-in clinic seeking help. But if that same patient is having chest pains in the middle of the night and can't reach his primary care doctor, he might go to the emergency room.

If an ER doctor examines the patient and decides the pains were only indigestion and not a heart attack, the doctor would likely enter a diagnosis code that didn't match with Anthem's approved list of emergency diagnosis codes. Then the hospital or the patient, or both, could be on the hook for thousands of dollars in unreimbursed claims.

Anthem and other big insurers have said minor injuries should be treated by a primary-care physician or at a lower level of care, such as a retail clinic or urgent-care clinic.

"What we've seen over the last three or four years is a gradual, increased use of the emergency room," said Dr. Joseph Fox, medical director for Anthem's Indiana operations, told IBJ in 2017, as it began implementing the policy. "And some of those visits could be performed at a lower-cost site of service."

But as in the case involving chest pains, patients might not always know the difference.

Too many ER visits?

Nationally, nearly three-quarters of ER visits are for non-emergencies, Anthem said in 2017. And at that point, insurers had been trying to discourage unnecessary use of the ER for years, sending brochures and letters to members, employers and benefits managers.

A national study published by Indianapolis-based Truven Health Analytics in 2013 found that 71% of ER visits were unnecessary or could have been avoided. The study analyzed insurance claims for more than 6.5 million ER visits in 2010 and found that most patients could have been treated in a primary care setting or did not require immediate attention.

But the American College of Emergency Physicians has pushed back, saying the true number is much lower. The organization, based in Irving, Texas, said fewer than 8% of ER patients are classified as "non-urgent" by the Centers for Disease Control and Prevention. The CDC's definition of non-urgent includes such conditions as broken bones and bronchitis.

Anthem's policy of denying or modifying claims caused an uproar among doctors and patient advocates, who said that patients might start to second guess whether their middle-of-the-night chest pains were a heart attack. They feared patients might avoid going to the ER for a true emergency if they are frightened by the prospect of receiving a large medical bill.

Anthem said it developed its list of hundreds of diagnosis codes it considers to be non-emergencies with board-certified ER doctors employed by the company.

In response, the American College of Emergency Physicians said the list of medical diagnoses could violate the "prudent layperson standard," which is part of federal law. That standard requires that insurers cover a person's symptoms, not the final diagnosis.

It says any person who suffers from symptoms that appear to be an emergency, as determined by an average layperson, should not be denied emergency treatment and insurance coverage if the final diagnosis does not turn out to be an emergency.

Seeking a court seal

The 11 Indiana hospitals challenging Anthem are asking a judge to confirm the arbitration decision, which was finalized in February.

The hospitals in the group include Lutheran Health System in Fort Wayne and Porter Regional Hospital in Valparaiso. They are all owned directly or indirectly by Community Health Systems of Franklin, Tennessee, a large, for-profit company that rang up $3.2 billion in revenue last year. (It is unrelated to Indianapolis-based Community Health Network).

In recent weeks, the case bounced between two courts, both based in Indianapolis. In both cases, the hospitals filed the cases as plaintiff, seeking to have a judge confirm the arbitration award, and naming Anthem as the defendant.

The hospitals originally filed the case in U.S. District Court in March. Anthem quickly moved to seal the petition, along with the arbitration and contract exhibits.

"The information should be maintained under seal and from the public eye, despite its potential materiality to this case, to give effect and enforcement to contract terms, the confidential nature of arbitration proceedings and to the protective order in place in the arbitration," Anthem wrote March 31 in its motion.

In response, the federal court automatically sealed much of the docket on a provisional basis.

But just one day later, the hospital system voluntarily dismissed the federal motion. It told IBJ it did so in response to a U.S. Supreme Court ruling limiting federal jurisdiction on arbitration awards.

Nine days later, the hospital group filed a nearly identical petition and set of exhibits in Marion County Superior Court. Again, Anthem moved to seal much of the record, but as of midweek, the documents remained unsealed.

Considering symptoms

The relationship between the hospitals and Anthem seemed on its face to be a standard one for treating Medicaid patients. Under the arrangement, Indiana's Medicaid program gives Anthem a fixed monthly payment for each enrolled member for use in paying for covered costs and services. Anthem agrees to pay the

See next page

Case at a glance

Plaintiffs

A group of Indiana hospitals all indirectly owned by Community Health Systems, a Fortune 500 hospital chain based in Franklin, Tennessee, that is not related to Indianapolis-based Community Health Network.

- Bluffton Regional Medical Center, Bluffton
- Dukes Memorial Hospital, Peru
- Dupont Hospital, Fort Bluffton Regional Medical Center, Wayne
- Kosciusko Community Hospital, Warsaw
- La Porte Hospital, La Porte
- Lutheran Hospital of Indiana, Fort Wayne
- Orthopedic Hospital of Lutheran Health Network, Fort Wayne
- Porter Regional Hospital, Valparaiso
- Rehabilitation Hospital of Fort Wayne, Fort Wayne
- St. Joseph Hospital, Fort Wayne
- Starke Hospital, Knox

Defendant

Anthem Inc., a Fortune 500 company based in Indianapolis, the predominant health insurer in Indiana.

Court

Marion County Superior Court

So far

- The hospitals alleged Anthem did not reimburse them for certain services at their most recent contracts' agreed rates and brought a claim to arbitration.
- Anthem brought a counterclaim, alleging the hospitals refused to comply with the contracts.
- The issue went to arbitration in 2019, and Anthem says it made full payment on the arbitration award. Terms of the arbitration remain secret.
- The hospitals are now demanding further, unspecified payment over disputed claims for medical treatment.

Sources: court filings, IBJ research

Continued from previous page

hospitals for treating the patients.

But the relationship between Anthem and hospitals took a big turn in 2017, when the insurer started restricting ER payments.

Within two years, the hospital system had gathered enough evidence of what is said was improper behavior by Anthem to submit a complaint to a federal arbitrator. It said a patient or a hospital should not have to worry whether the condition would be approved based on the doctor's final diagnosis.

The law, the arbitrator wrote, was "crystal clear" that to deny or downcode an emergency claim, Anthem must first consider all the pertinent information and documentation with a focus on the patient's symptoms, and not just a final diagnosis code.

"Anthem does not do so," the arbitrator, wrote in his interim decision on Oct. 21.

Lash, the hospitals' attorney, estimated there are more than 30,000 additional claims affected by Anthem's policy, which could cost the insurer more than $12 million. He said Anthem has yet to make good on that amount.

Anthem did not respond to IBJ's questions about whether it agrees with that amount or plans to pay it.

Lash said other health insurers have been taking similar steps with restrictive ER reimbursement policies in recent years and are also facing a pushback from hospitals. "We have been litigating cases like this for hospital providers across the country for years, against other insurance companies that are engaging in these kind of emergency room downgrade policies," he said.

Lash said he was not at liberty to discuss the details of those proceedings or disclose the outcomes. "But I'll just say that we've been successful in those endeavors, consistently."

Secrecy waning

The confidentiality surrounding the case, and particularly Anthem's efforts to seal the exhibits, are typical of the longtime secrecy over health care prices charged by hospitals and the discounts negotiated under contract by insurers for their members under various health plans, some longtime observers say.

"Once Anthem has to disclose what its rates are, well, then all of a sudden, United, Cigna and all the other major players say, this is what they're getting, why can't we get the same," said Ed Abel, former director of health care practice at Indianapolis-based Blue & Co., an accounting and consulting firm.

Abel

"And hospitals feel the same way," he added. "They don't want to give United and Cigna, etc., the same discounts that they're giving to Anthem.

Such secrecy has started to wane in the last year, thanks to new federal rules that require hospitals to post prices online for 300 "shoppable services," such as a CT scan or a blood test.

The new rules also require hospitals to post a machine-readable file of every negotiated price paid to the hospital by every insurer it had a contract with for in-network care, plus the list price, cash price, and the high and low prices for those services.

The American Hospital Association challenged those provisions in court, saying the prices, known as the chargemaster, were private and could hurt their operations if published. But the association lost its fight, and hundreds of hospitals have yet to comply with the new requirements.

"The agreed rates and the underlying hospital chargemasters were viewed as strictly confidential," said Nicolas Terry, executive director of the Center for Law and Health and the Indiana University McKinney School of Law. "Hence the hospital system pushback and in many cases non-compliance with the Hospital Price Transparency Rule."•

Terry

company Index

This index includes Indiana-based companies or companies with a major local presence. It does not include companies mentioned in letters to the editor, lists, charts and records. The page numbers listed refer to the pages where articles begin.

Not-for-Profit of Note

Special advertising feature

The Village of Merici

Mission

The Village of Merici provides a unique affordable housing model and community opportunities for adults with intellectual or developmental disabilities.

Top Officials

Colleen Renie
Executive Director

Toby McClamroch
Board Chair

Founded: 2007
Number of employees: 53
Annual Revenue: $1,200,000

Contact

5707 Lawton Loop E. Dr.
Indianapolis, IN 46216
Phone: 317-292-9408
villageofmerici.org

Board

Toby McClamroch*
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Frank Hutnicke
Anesthesiologist, retired

P. J. Loehrer
Communications Specialist

Jack Mahoney
Gregory & Appel Insurance

Dave McDowell
Techlite

Loui Lord Nelson
Raise, Inc.

Deborah Whitfield
Community Health Network

Jeffrey Yu
Column Capital Advisors, LLC

* *Executive Leadership*

Goals

The Village of Merici empowers adults with intellectual or developmental disabilities to live independently in a self-directed manner by providing affordable housing and one-on-one services unique to individual needs. With over 5,000 adults with IDD in Indianapolis, the need for housing options and support for independent living is great.

Over the next two years, VOM will expand to serve more individuals with projects underway on the northeast side and in Carmel.

Opportunities

Fund

There are lots of ways to support the Merici mission:

- Make an online donation – villageofmerici.org
- Designate your corporate match
- Participate in an annual VOM event
- Get to know us and spread the word

Volunteer

There are many ways to become involved:

- **Merici City Rides** – volunteer to drive an adult with disabilities to work
- **Programs** – share a skill or teach a class
- **Events** – help with an annual signature event
- Have your own volunteer ideas? Give us a call.

Give

By supporting the mission of the Village of Merici, you provide the means for an adult with disabilities to learn life skills and the ability to live a self-sufficient life. Your support is appreciated.

Top Funding Sources

76% Programs & Services
21% Individual & Corporate
3% Grants

Geographic Service Area

The Village of Merici provides affordable housing and direct services within Indianapolis.

Information was provided by The Village of Merici. Profiled organizations must be based in or serve the Indianapolis area, must have Internal Revenue Service tax-exempt status, and must be willing to provide IBJ with detailed financial information.

*P.O. Box 315/ 29 Association Drive, Manchester, ME 04351 * Phone: 207-623-1101 * Fax: 207-623-4228 * www.mainedo.org*

Testimony of the Maine Osteopathic Association
Before the Committee on Health Coverage, Insurance and Financial Services

Comments Prepared for Special Committee Meeting: Thursday, April 28, 2022 10:00 AM

Senator Sanborn, Representative Tepler, and distinguished members of the Committee on Health Coverage, Insurance and Financial Services,

My name is Amanda Richards and I am the Executive Director of the Maine Osteopathic Association (MOA). I am pleased to provide these comments on behalf of the MOA.

The Maine Osteopathic Association is a professional organization representing approximately 400 osteopathic physicians as well as more than 700 residents and students. Our mission is to "serve the Osteopathic profession of the State of Maine through a coordinated effort of professional education, advocacy and member services in order to ensure the availability of quality osteopathic health care to the people of this State."

We were concerned, but not completely surprised by Maine Medical Center's recent announcement that they have made the decision to leave Anthem's coverage network starting in 2023. MOA members in Anthem's provider network have also expressed numerous contracting and billing issues and concerns. We would like to take this opportunity to lay out a few key points from our perspective:

- First and foremost, Anthem's payment policies are out of line with other payers, both public and private.
- Anthem does not follow their own stated payment policies. Attempts by our physicians to comply are met with denial explanations that are difficult to interpret and inconsistent with Anthem's stated policies.
- Attempts by individual physicians' practices to communicate with Anthem regarding payment problems are extraordinarily frustrating (long phone wait times, dropped calls, inappropriate responses, etc.).
- The amount of time Anthem takes to adjudicate appeals of denials is extraordinary and out of line with other payers.
- The Maine Osteopathic Association (MOA) has made every effort to work with Anthem, having met at least 8 times over the past two years. The MOA has offered to work with Anthem to enhance communication between our physicians and Anthem personnel.
- Despite our attempts to enhance communication and cooperation in a professionally respectful manner, Anthem representatives have made false statements to our physicians regarding our organization's communications with Anthem.

We are concerned that these issues have persisted and escalated to the point that they are threatening the viability of many small practices, left with the difficult choice to continue to fight for every dollar owed for valid medically necessary services, or to consider terminating their contracts with Anthem and leave loyal patients in the lurch. Given the high percentage of Mainers covered by Anthem plans, these decisions have big impacts in within the realm of healthcare access in Maine and as such are not just provider-insurer contract issues.

We appreciate the opportunity to share some information with you based upon our members' experiences with Anthem, and ultimately our concerns about their practices. Please do not hesitate to contact us at info@mainedo.org if you have any questions. Thank you.