MAINE ASSOCIATION OF HEALTH PLANS

Testimony of Katherine Pelletreau
to the Joint Standing Committee on Health Coverage, Insurance and Financial Services

Neither For Nor Against

LD 1258 An Act To Implement the Recommendations of the Stakeholder Group Convened by the Emergency Medical Services' Board Related to Reimbursement Rates for Ambulance Services by Health Insurance Carriers and To Improve Participation of Ambulance Service Providers in Carrier Networks

April 20th, 2021

Good Morning Senator Sanborn, Representative Tepler, Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services:

My name is Katherine Pelletreau, and I am the Executive Director of the Maine Association of Health Plans (MeAHP). MeAHP has five members including Aetna, Anthem Blue Cross and Blue Shield, Cigna, Community Health Options and Harvard Pilgrim Health Care. Collectively, MeAHP's members provide or administer health insurance coverage to over 600,000 Maine people. The organization's mission is to improve the health of Maine people by promoting affordable, safe and coordinated healthcare.

This bill seeks to implement a portion of the recommendations made by the LD 2105 Ambulance Work Group. I served on the work group in addition to three representatives from carriers (Anthem, Harvard Pilgrim Health Care, and Community Health Options) along with ambulance providers and others.

The recommendations of the group were generally supported by many of the carriers and the other members of the group to achieve a clear set of policy suggestions for the Legislature. The WG however, did not provide legislative language. Now that we have that, we suggest several amendments to better reflect the intention underlying the recommendations.

While we understand the reasoning, we are disappointed that the recommendations were not held together as a package but split up between Committees. From our perspective, this weakens the whole proposal. By carving out the recommendations for MaineCare, we see them as less likely to pass, and without them, the cost shifting to private insurers will continue to grow. As you may recall from the Report, private carriers represent less than 10% of claims volume for ambulance services yet pay a far larger portion (around 27% as reported by EMS survey respondents) of revenues.

Our overall goal is to have more ambulance providers in network and the payment differential between in (IN) and out of network (OON) providers is intended to incentivize network participation.

Proposed Amendment #1: Clarify the difference between charges and rates and ensure that the 5% limit on increases for both charges and rates applies to both in and out of network providers.

Section 3 of the bill proposes reimbursement rates for ambulance services. While we agree with the concepts outlined, there are considerations missing from the language as presented.

The new payment standards in the bill represents a significant increase over what is currently paid (setting aside the temporary requirement that carriers pay charges). In the Report there is a chart (Ambulance WG Report, page 11) that shows the Medicare multiplier paid by carriers is between 1.14 and 1.68. This bill will take that amount up to 1.8 or 180% of Medicare for OON and 2.0 or 200% of Medicare for IN providers.

With that in mind, the proposed language does not adequately distinguish between charge and rate. In an in-network scenario where a carrier is currently paying well below the 200% of Medicare standard under the statute, the proposal limits the increase in charges to 5% annually. It is our understanding the intention is also to limit the annual increase in payment rates to 5%.

In an OON situation where a provider is currently paid 160% of Medicare, they also need to be limited to 5% increases per year up to 180%. For in-network providers who are paid less than 180%, there would be an incentive to drop out of network as they would be eligible for 180% sooner. In fact, one of our Plans has already seen this occur in two cases with providers threatening to go out of network if not paid at the 200% rate.

We note that there is an administrative burden of having to adjust contracts annually on both sides but expect that to diminish over time as contracting and payment rates become more streamlined.

Proposed Amendment #2: In Section 3, paragraph C, remove "in the same amount" and replace with "substantially similar".

In paragraph C, carriers are directed to add on payments for providers in rural and super rural areas of the state, similar to Medicare. While we agreed on this concept, we were careful not to recommend identical payments to avoid carriers having to systematize tracking Medicare adjustments to these add-ons. Our intention is to pay similarly but not necessarily identically, and we would ask that this language be clarified.

Proposed Amendment #3: In section 3, paragraph D, protect against rapid increases across the ambulance provider marketplace by setting 1/1/21 as the date after which increases are limited to 5%.

Changes should also be made to paragraph D which establishes that the limit on 5% per year increases only applies *on the effective date of this subsection.* This creates a 3- or 4-month period for ambulance providers to shift their rates to the highest possible amount, even if they have been charging far less up to this point. This would undermine carrier attempts to manage costs and cause a rapid increase across ambulance provider marketplace. We suggest that a retrospective date such as 1/1/2021 be put into the bill to avoid this behavior and meet the intention of the recommendations to limit increase to 5% per year up to 180% or 200% of Medicare.

Proposed Amendment #4: Make rulemaking in Section 4 major substantive and set a completion date of 7/1/2022.

Section 4 of the bill proposes rulemaking by the Emergency Medical Services Board to establish rules and protocols that evaluate the need for any new ambulance service. For us, this was an especially important part of the discussion and recommendations and intended to address the over and undersupply of ambulance services in different areas of the state.

The Ambulance Work Group Report includes a map of Maine prepared by MHDO showing the distribution of ambulance providers in the state and making the visual case clear (Ambulance Work Group Report, Page 10). Many of the Plans have trouble contracting with providers and for services such as non-emergency transport, especially in more rural areas of the state. This rulemaking is intended to increase access in areas that are underserved and better manage competition in areas that have a proliferation of ambulance providers. We recommend that this be changed to major substantive rulemaking given the strong competing interests. This matter is urgent and should not be delayed, therefore we suggest a date of 7/1/2022 be established for completion of the rulemaking.

Section 6 establishes a process and stakeholder group for reviewing financial health and costs of ambulance service providers. We are cautious about this effort as it appears intended to link further reimbursement increases to cost needs of ambulance services. Any effort like this needs to parse out the different types of providers – i.e. municipal, hospital, independent, etc. and their various revenue streams.

Thank you for the opportunity to offer these comments.