**HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES**
**February 14, 2018**
**Testimony Opposing House Bill 2575**
**Melissa Panettiere**
***Director of Governmental Affairs***
**Blue Cross and Blue Shield of Kansas City**

Chairman Hawkins and Members of the Committee, my name is Melissa Panettiere and I am here today on behalf of Blue Cross and Blue Shield of Kansas City to testify against House Bill 2575.

Blue Cross and Blue Shield of Kansas City is a not-for-profit health plan serving residents in the greater Kansas City area, including Johnson and Wyandotte counties in Kansas and 30 counties in Northwest Missouri. Our mission is to use our role as the area's leading health insurer to provide affordable access to healthcare and improve the health and wellness of our members. While we appreciate the intent of this legislation to bring costs down we would like to see data that ensures the operational complexities of such a program are worth the investment before mandating this on the private market.

"Right to Shop" programs are sold as a way to allow consumers to take control of their health care, lowering costs, and increasing options. However, this requires an engaged consumer who understands health insurance. Research suggests health insurance literacy rates for the average adult consumer are very low. Health literacy isn't just about understanding the terminology, it is also involves understanding how to make the right choices. According to the National Assessment of Adult Literacy, only 11 percent of adults have proficient health literacy. In other words nearly nine out of ten adults may lack the skills needed to manage their health care and prevent disease. Without engaged consumers who understand health insurance the program will produce little or no savings.

Aside from the question of whether or not consumers will participate in the program, and at what rate, there are operational complexities that need to be thought through before imposing such a broad program on the commercial market. For instance, the incentives members receive appear to be taxable and which entity (health plan, or self-insured employer, etc.) would provide the 1099 form is unclear. In addition, it is not clear whether insureds or their employers would be able to contribute to an HSA account if this mandate is required on an HSA compatible health insurance plan. If the member has an HSA with a high-deductible plan, the health insurer may not be able to pay the incentive until the insured met his deductible Otherwise providing the incentive could disqualify the insureds HSA contribution. How does one account for the geographical disparities within the state with respect to average price? There is no defined market for the average price of a shoppable health care service so a consumer in a lower- cost area of Kansas could gain more shared savings and even obtain a

lower cost provider outside of this state or even the country. An individual making a health care decision based on cost alone may choose suboptimal care in Mexico, for instance, simply because it is cheaper which could ultimately lead to subsequent higher priced follow-up care. Quality shouldn't be sacrificed for affordability especially since we are able to offer both to our members today. This bill requires the insurer to "base the average amount of the average allowed amount paid to an in-network health care entity for a procedure or service under the insured's health plan." The procedures and services are unlimited in the current draft, presenting additional operational complexities that could be avoided by limiting the services and procedures to the most common procedure or service.

The program outlined in this bill also applies to all health insurance carriers, including HMOs and EPOs. HMOs and EPOs manage health insurance costs more efficiently by requiring that all or some of the covered services be rendered by in-network providers. This bill would require that we pay for out-of-network services thus, eliminating the ability to have a closed network as an option for employers. In addition, primary care providers are engaged in managing their patient's health and providing appropriate referrals to specialty care. Just two years ago, this body overwhelming approved of HB2454 allowing for insurers to respond to market demands to offer EPO product as a way to keep costs under control. This bill would essentially eliminate HMOs and EPOs in the state of Kansas and require that all insured plans sold be PPO plans. If the market demands health insurers provide products that include shared savings programs then the industry will quickly adapt. Currently there is demand for products without out-of-network coverage. Let the market drive our decision as opposed to another government mandate telling us what to offer which could lead to unintended consequences such as driving up health care costs or poor health care outcomes.

A shared incentive program is untested in Kansas, several assumptions are being made on the take up rate and the consumer's ability to shop for services. Only after we have seen solid data can we know for sure that the savings will outweigh the investment cost required to get the program up and running. Therefore, we respectfully request the committee to consider requiring this program be implemented by the State Employee Health Plan first as a pilot project in order to collect solid utilization and cost data before mandating this monumental change on the private market.