IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC. **PLAINTIFF**

V. **CAUSE NO. 3:24-cv-379-HTW-LGI**

MIKE CHANEY, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE OF MISSISSIPPI **DEFENDANT**

MISSISSIPPI ASSOCIATION OF HEALH PLANS, INC.'S SUPPLEMENTAL SUPPORT FOR MOTION FOR PRELIMINARY INJUNCTION

The Mississippi Association of Health Plans, Inc. ("MAHP") files this Supplemental Support for its Motion for Preliminary Injunction [Dkt. No. 9] as further support for its request for a preliminary injunction to prohibit Defendant Mike Chaney, in his official capacity as Commissioner of Insurance of Mississippi (the "Commissioner"), from exercising his statutory or regulatory authority to enforce or implement the provisions of House Bill 1489. In support, MAHP relies on its Motion for Preliminary Injunction and the Declaration of Jon Andrew Maddox attached as Exhibit 1 thereto [Dkt. 9], its accompanying Memorandum Brief in Support of Motion for Preliminary Injunction [Dkt. 10], additional evidence or testimony to be offered at the hearing on the Motion, and the following Supplemental Support:

A. Declaration of Bryan Lagg ("Exhibit 2"); and

B. Declaration of Aaron Riley Sisk ("Exhibit 3").

MAHP has consulted with counsel for the Commissioner regarding this supplementation, and the parties are in agreement to an extension of the time for the Commissioner to respond to the Motion by fourteen (14) days.

MAHP requests the Court to grant its Motion for Preliminary Injunction and such other relief, whether in law or in equity, as the Court may deem just and proper following a hearing on this matter.

Dated: August 1, 2024.

Respectfully Submitted,

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC

By: *[/s/ James A. McCullough, II]*
One of Its Attorneys

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CERTIFICATE OF SERVICE

I hereby certify that on this day, a true and accurate copy of the foregoing was electronically transmitted to the Clerk of the Court using the ECF System for filing, which delivered notice of same to all counsel of record.

Dated: August 1, 2024.

/s/ James A. McCullough, II
James A. McCullough, II

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC. PLAINTIFF

V. CAUSE NO. 3:24-cv-00379

MIKE CHANEY, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE OF MISSISSIPPI DEFENDANT

DECLARATION OF BRYAN LAGG

1. My name is Bryan Lagg. I am over 21 years of age and am competent to make this declaration. I am employed by Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company ("Blue Cross"), as Senior Vice President, Strategic Partnerships. This Declaration is given based on my own personal knowledge and upon information obtained from the records of Blue Cross.

2. Blue Cross is a member of the Mississippi Association of Health Plans ("MAHP"), a non-profit association of health insurers in the State of Mississippi. I am authorized by Blue Cross to make this Declaration in support of MAHP's Motion for Preliminary Injunction in this case.

3. Blue Cross is one of Mississippi's leading healthcare insurers, having provided and managed affordable health and wellness benefit plans for Mississippians for more than 75 years. In that role, Blue Cross insures and administers health and wellness benefit plans covering Mississippians who are individual policy holders or employees of employers with group benefit plans (collectively "Members"). Blue Cross is an issuer and administrator of health benefit plans as defined in Miss. Code Ann. § 83-63-3, and an issuer of accident and sickness insurance policies

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as defined in Miss. Code Ann. § 83-9-1. Benefits provided by Blue Cross' benefit plans and insurance policies with its Members are renewed annually on January 1, and any modifications to the coverage structure of the plans become effective at that time.

4. Blue Cross' benefit plans and insurance policies provide coverage in their schedules of benefits for ambulance services, defined as "Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured." With regard to ground ambulance services, Blue Cross benefit plans further provide:

> Benefits as specified in the Schedule of Benefits will be available for the following covered Ambulance Services when Medically Necessary:
>
> > Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
> >
> > a. from the place where the Member is injured by accident or stricken by illness to the nearest Hospital where treatment is to be given;
> >
> > b. from a Hospital where a Member is an Inpatient to another Hospital or free-standing facility to receive specialized diagnostic or therapeutic services not available at the Hospital of origin and back to the Hospital of origin after such services have been rendered;
> >
> > c. from a Hospital to another Hospital when the discharging Hospital has inadequate treatment facilities and the receiving Hospital has appropriate treatment facilities;
> >
> > d. to a Hospital or Ambulatory Surgical Facility for Outpatient care of an Accidental Injury or a Medical Emergency.
> >
> > ***
> >
> > Ambulance Service Benefits will not be provided for a Member's comfort or convenience

5. One of the ways Blue Cross provides its Members with affordable healthcare premiums while facilitating Members' health and wellness is by entering into contracts with healthcare providers whereby those providers are included in Blue Cross' healthcare provider

network. In consideration of the advantages providers receive by being a Blue Cross Network Provider, Network Providers agree, among other things, to be reimbursed by Blue Cross at specific Allowable network rates established by Blue Cross for specific covered services provided. The Allowable paid to providers for covered services in accordance with plan terms constitutes confidential and proprietary commercial information of Blue Cross, but Allowable rates paid to Network Providers generally reflect a material discount on the provider's typical billed charges. As a central matter of Blue Cross' plan administration, Blue Cross plans authorize it to pay reduced benefits for covered services provided to Members by providers who are not in the Blue Cross network (i.e., out of network providers).

6. Blue Cross has entered into Network Provider agreements with numerous ambulance service providers who have agreed to provide covered ambulance services for its Members at Blue Cross Allowable network rates. At the present time, out of network ambulance service providers are reimbursed for most covered services at the same Allowable rate as are network ambulance service providers.

7. Blue Cross generally issues its plans on a calendar year basis, referred to as a "plan year," making any adjustments to its benefits structure and other plan terms effective as of January 1st of the plan year. Blue Cross annually submits its amendments to plan forms, including benefits structure, to the Mississippi Insurance Department ("MID"). Mississippi law requires that certain plan forms and terms must be submitted to and approved by the Commissioner of Insurance as complying with state law, and Mississippi law requires Blue Cross to give notice to its Members of plan changes at least seventy-five (75) days before their effective date. Blue Cross typically submits its plan amendments at least 10 days before the start of this Member notice period in order to obtain timely approval. A finding by the Commissioner that Blue Cross' plan forms which

require approval do not comply with HB 1489 will impact its ability to give due and timely notice of plan coverage and rate changes to its Members under Mississippi law.

8. Blue Cross generally sets its plan premium rates for upcoming plan years in May and June of the preceding year, and files its rates with MID on or before the deadline established annually by the Commissioner of Insurance. Blue Cross submitted its premium rates for the current 2024 plan year on June 30, 2023, as required by the Commissioner. Premium rates for plan year 2025 were submitted to the Commissioner on June 21, 2024.

9. Blue Cross utilizes actuary modeling to establish premium rates for its individual and small group plans and policies. In calculating premium rates, Blue Cross' actuaries rely on historical claim information and take into account, among other factors, the anticipated frequency of covered claims and the expected total claims reimbursement cost. For large group plans, Blue Cross utilizes experience rating. Experience rating utilizes historical claim and payment information for each large group plan to estimate anticipated future claims and payments that group is likely to experience, and uses that estimate to establish the following year's premium.

10. The process of setting premium rates under either method is dependent on having a clear understanding of what medical services are to be considered covered benefits under a plan in the coming year, and having a known or reasonably estimable "allowable" for covered services. Without a clearly defined description of precisely what claims will be covered by a plan, Blue Cross cannot utilize its historical claims data to reasonably estimate the total number, frequency or type of covered claims it is likely to experience in the coming plan year. Furthermore, without a known or reasonably estimable allowable to be paid for certain covered claims, Blue Cross cannot reasonably estimate anticipated plan reimbursement costs. Without clearly defined covered benefits and known or reasonably estimable reimbursement rates, Blue Cross' ability to set plan

premiums that are reasonably priced for its Members to account for likely plan costs will be severely hampered.

11. I am familiar with House Bill 1489, the statute at issue in this lawsuit. As part of my job duties for Blue Cross, I am familiar with the processes used by Blue Cross to estimate premiums for plan year 2024, which were determined in 2023 and filed with the Commissioner on June 30, 2023, and for plan year 2025, which were filed with the Commissioner on June 21, 2024. The mandatory reimbursement language in Section 2 has created significant impacts to Blue Cross' plans currently in effect, and created significant uncertainties that impacted the premium rate setting process for plan year 2025.

12. It is Blue Cross' understanding that few, if any, ambulance service providers enter into contracts with counties, municipalities or special purpose districts or authorities to provide agreed upon rates for their residents. To the extent any ambulance company has entered into such special rate contracts, the information has not historically been provided to Blue Cross. Additionally, Blue Cross was unable to locate any such contracts being publicly available to it during the premium rating process. As of this date, Blue Cross has been unable to determine if any such contractual reimbursement rates exist.

13. Blue Cross is aware of the 2024 reimbursement rates for out of network ambulance service providers established for Medicare by the Centers for Medicare and Medicaid Services ("CMS") applicable to region 07302, which covers Mississippi. CMS reimbursement rates depend on the nature of the ambulance service provided and claimed based on up to nine (9) Current Procedural Terminology ("CPT") codes, ranging from a low reimbursement of $0.00 for some services not covered to a high reimbursement of $817.51 for other services. Without knowing the specific ambulance services required to be covered by House Bill 1489, it is difficult to identify

which CMS reimbursement rates may be applicable to the calculation called for in Section 2. However, an allowable reimbursement rate of 325% of the CMS reimbursement rate would be significantly higher than the current allowables under Blue Cross' plans.

14. Section 2 of the Bill provides that Blue Cross must reimburse out of network ambulance service providers the amount of their billed charges if that amount is (a) greater than contract rates agreed to with counties, municipalities or special purpose district, or (b) 325% of CMS' rate. I have reviewed claims data for ambulance service claims filed by out of network ambulance service providers for dates of service in the first six months of 2024. During that time period, more than 4,600 lines of claims were filed by ambulance service providers with billed charges totaling nearly of $6.3 Million. Over this timeframe, billed charges submitted by ambulance companies were almost always higher than 325% of CMS' reimbursement rate. During this time, the average billed charges received per CPT code differ from the Medicare rate by a range of 297.61% to a high of 496.33%, and the highest billed charges received per CPT Code differ from the Medicare rate by a range of 810.69% to a high of 1,407.59%.

15. For out of network ambulance claims filed between July 1, 2024 and July 22, 2024, average billed charges received per CPT code differ from the Medicare rate by a range of 238.76% to a high of 654.99%, and the highest billed charges received per CPT Code differ from the Medicare rate by a range of 269.46% to a high of 1,921.48%.

16. Blue Cross's premium rates for the current 2024 plan year were established in June, 2023, and filed with the Commissioner on June 30, 2023. Blue Cross did not and could not anticipate the legislature would pass legislation requiring reimbursement of out of network providers at amounts up to their full billed charges. These premium rates were established based in part on Blue Cross' estimation of claim costs taking into account claims history and payments

at its contract allowable rates in its plans approved and issued effective January 1, 2024, which rates were materially lower than 325% of CMS' reimbursement rates. Requiring Blue Cross to begin reimbursing out of network ambulance service providers at their billed rates on and after July 1, 2024, will result in costs significantly higher than Blue Cross estimated when it filed its 2023 premium rates.

17. Furthermore, in future years, a requirement to reimburse certain providers at whatever amount they decide to bill will greatly impact Blue Cross' ability to reasonably estimate premiums. Blue Cross is committed to providing affordable health care coverage for its Members and to use its best efforts to accurately estimate premium rates, but Section 2 of the Bill will impose a significant negative affect on its ability to do so.

18. A larger concern to Blue Cross is the financial impact Section 2 will have on its Members. Like other health insurance companies, Blue Cross' plans include a patient responsibility portion for each claim which Members are responsible for paying, including co-insurance. The amount of co-insurance Members are required to pay under most Blue Cross plans is 20% of the plan allowable. Thus, by requiring a plan to increase it's allowable to any amount an out of network ambulance service provider decides to bill, Section 2 also increases the amount of the co-insurance Blue Cross Members will be required to pay out of pocket. Neither Blue Cross nor its Members could have anticipated this change when the plan was issued on January 1, 2024.

19. I am familiar with House Bill 1489, the statute at issue in this lawsuit. As part of my job duties for Blue Cross, I am familiar with the process of evaluating the terms of the Bill to determine what ambulance services were required to be included as covered benefits in health benefit plans, and I am familiar with the development of medical policies, claim filing guidelines

and claim processing guidelines for use in adjudicating claims submitted by providers and reimbursing for covered services pursuant to plan terms.

20. Processing and adjudicating insurance claims involves an intricate procedure. Providers submit claims to Blue Cross utilizing standardized claim submission forms on which providers identify specific services they provided to Members. Blue Cross utilizes claim processing guidelines to clearly define what medically necessary health care services are covered under its benefit plans, how claims for those services are to be processed and adjudicated, what the patient responsibility portion of allowed covered charges will be, and how much is to be reimbursed by the plan. Ambiguity in what services require coverage render it impossible to prepare meaningful and useful claim processing guidelines. Because of the ambiguity in Section 1 of the Bill, Blue Cross cannot determine precisely what services must be covered, and therefore, is hampered in preparing medical policies, claim filing guidelines and claim processing guidelines to ensure compliance with the law.

21. The Bill's definition of "alternative destination" is particularly ambiguous and has caused significant confusion in attempting to formulate guidelines. Section 1 references emergency-type services are required, including in the definition of "ambulance service providers" and by requiring an enrollee call for potential emergency services to trigger coverage of transportation to an alternative destination. However, by defining it as a "lower-acuity" facility providing "medical services," and using "including but not limited to" specific examples to include non-emergency facilities, Blue Cross is unable to decipher the types of facilities intended. It is substantially unclear, and Blue Cross is unable to determine, if an "alternative destination" is intended to include medical providers who do not provide any degree of emergency medical

services, or if coverage is required at the advanced life support rate to transport an enrollee to their personal physician or favorite clinic for routine, non-emergency care at the enrollee's request.

22. It is also substantially unclear whether an enrollee can choose whether he or she is taken to an "alternative destination" over a hospital's emergency department and, if so, whether he or she can choose among the seemingly unlimited types of "alternative destinations" as his or her preferred destination. Blue Cross is unable to determine from the Bill whether a Member must be afforded coverage when choosing to be transported to his or her personal physician or other preferred destination located in other municipalities and/or counties, while bypassing closer "alternative destinations." If the Member is not authorized under the Bill to make the determination, it is substantially unclear who decides and what that decision must be based on. These determinations are critical to analyzing whether any particular ambulance transport is medically necessary and/or consistent with Blue Cross's medical policies, yet the Bill is unclear on these matters.

23. Additionally, Blue Cross cannot clearly distinguish between the requirements to cover ambulance services of "treat or assess an enrollee in place," "triage" (without transport), and for "[a]n encounter between an ambulance service and enrollee that results without transport of the enrollee," and the Bill does not define any of these terms to afford any guidance.

24. The Bill requires coverage for any "encounter between an ambulance service and enrollee that results without transport of the enrollee." The term "encounter" is undefined in House Bill 1489, and Blue Cross is unaware what level of service an ambulance service provider must actually provide to an enrollee, if any at all, to trigger coverage. Without a transportation requirement, Blue Cross is unaware of how any "encounter" will require emergency ambulance services such that coverage at advanced life support rates is required. Blue Cross also cannot

determine how the term "encounter" differs from the Coverage Mandate's requirement to provide coverage for an ambulance service provider to "assess" a subscriber/insured, or the difference, if any, between the requirement to provide coverage to "assess" and "triage" a subscriber/insured, as House Bill 1489 provides no guidance or standard whatsoever.

25. The healthcare industry utilizes nationally adopted and standardized CPT codes created and maintained by the American Medical Association to identify the services provided. Providers use CPT codes to identify the specific services provided, and Blue Cross use CPT codes submitted to evaluate available coverage and compliance with plan terms. I am not aware of any CPT code that an ambulance service provider or Blue Cross may use when the ambulance service provider merely "encounters," "assesses," or "triages" a Member. The lack of CPT code, coupled with the Bill's vague language make it impossible for Blue Cross to consistently assess whether benefits are available for these services. Because the Bill's terms are vague and undefined, Blue Cross cannot look to ordinary procedures, including CPT codes, to process claims.

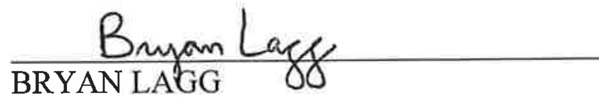
26. Further, Blue Cross cannot decipher whether coverage for ambulance services and transportation at the advanced life support rates would be triggered when a caller contacts an ambulance service directly, not through a governmental E-911 service. Blue Cross employees must have clear guidelines to determine whether benefits are available for a claim. Without clarity on whether a call to a local government's E-911 service is required, Blue Cross is unable to draft medical policies that comply with the mandates of House Bill 1489 with certainty. Blue Cross is unable to decipher whether ambulance services must be triggered by contacting a local government's E-911 service for coverage to apply.

27. In short, if a Member or an ambulance service provider were to contact Blue Cross to inquire what benefits are available for ambulance services referenced in Section 1 of the Bill, Blue Cross would be unable to meaningfully provide a response.

At this time, I have nothing further to say.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the law of the United States of America that the above is true and correct to the best of my knowledge and belief.

Dated: August 1, 2024.



BRYAN LAGG

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC. **PLAINTIFF**

V. **CAUSE NO. 3:24-cv-00379**

MIKE CHANEY, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE OF MISSISSIPPI **DEFENDANT**

DECLARATION OF AARON RILEY SISK

1. My name is Aaron Riley Sisk. I am over 21 years of age and am competent to make this declaration. I am employed by Centene Corporation ("Centene"), as President and CEO of Magnolia Health Plan, a subsidiary of Centene. This Declaration is given based on my own personal knowledge and upon information obtained from the records of Centene and Magnolia Health Plan.

2. Centene is a member of the Mississippi Association of Health Plans ("MAHP"), a non-profit association of health insurers in the State of Mississippi. I am authorized by Centene to make this Declaration in support of MAHP's Motion for Preliminary Injunction in this case.

3. Centene is one of Mississippi's leading healthcare insurers. Centene was founded in 1984 with an objective of serving under-insured and uninsured individuals to obtain quality health care through affordable health insurance. Since that time, Centene has become the largest and longest-running health insurance provider in the health insurance marketplace. Centene is an issuer of health benefit plans as defined in Miss. Code Ann. § 83-63-3, and an issuer of accident and sickness insurance policies as defined in Miss. Code Ann. § 83-9-1. Benefits provided by Centene's benefit plans and insurance policies with its Subscribers are renewed annually on

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January 1, and any modifications to the coverage structure of the plans become effective at that time. Centene's insurance policies provide coverage for medically ambulance services. With regard to ground ambulance services, Centene's 2024 standard Ambetter plan document provides the following:

> Covered service expenses will include ambulance services for ground and water transportation, transportation from home, scene of accident, or emergency condition:
>
> 1. In cases where the member is experiencing an emergency condition, to the nearest hospital that can provide emergency services appropriate to treat the member's emergency condition.
> 2. To the nearest neonatal special care unit for newborn infants for treatment of illnesses, injuries, congenital birth defects, or complications of premature birth that require that level of care.
> 3. Transportation between hospitals or between a hospital and skilled nursing or rehabilitation facility when authorized by Ambetter.
> 4. When ordered by an employer, school, fire or public safety official and the member is not in a position to refuse; or
> 5. When a member is required by us to move from a non-network provider to a network provider.
>   Prior authorization is not required for emergency ambulance transportation.
>   Note: non-emergency ambulance transportation requires prior authorization.
>   Note: Unless otherwise required by Federal or Mississippi law, if you receive services from nonnetwork ambulance providers, you may be balance billed.
>
> Exclusions: No benefits will be paid for:
>
> 1. Expenses incurred for ambulance services covered by a local government or municipal body, unless required by law.
> 2. Ambulance services provided for a member's comfort and convenience.
> 3. Non-emergency transportation

4. One of the ways Centene provides its Subscribers with affordable healthcare premiums while facilitating Subscribers' health and wellness is by entering into contracts with healthcare providers whereby those providers are included in Centene's healthcare provider network. In consideration of the advantages providers receive by being a Centene network provider, network providers agree, among other things, to be reimbursed by Centene at specific Allowable network rates established by Centene for specific covered services provided. The

Allowable paid to providers for covered services in accordance with plan terms constitutes confidential and proprietary commercial information of Centene, but Allowable rates paid to network providers generally reflect a material discount on the provider's typical billed charges. As a central matter of Centene's insurance policy administration, Centene policies authorize it to pay reduced benefits for covered services provided to Subscribers by providers who are not in the Centene network (i.e., out of network providers).

5. Centene has entered into network provider agreements with numerous ambulance service providers who have agreed to provide covered ambulance services for its Subscribers at Centene Allowable network rates. At the present time, out of network ambulance service providers are reimbursed for most covered services at the same Allowable rate as are network ambulance service providers.

6. Centene generally issues its policies on a calendar year basis, referred to as a "policy year," making any adjustments to its benefits structure and other policy terms effective as of January 1st of the plan year. Centene annually submits its policy forms, including benefits structure, to the Mississippi Insurance Department ("MID"). Mississippi law requires that certain plan forms and terms must be submitted to and approved by the Commissioner of Insurance as complying with state law, and Mississippi law requires Centene to give notice to its Subscribers of plan changes at least seventy-five (75) days before their effective date. In Centene's experience, plan terms requiring approval generally must be submitted thirty days or more before the start of this Subscriber notice period in order to obtain timely approval. A finding by the Commissioner that Centene's submitted plan forms do not comply with HB 1489 will impact its ability to give due and timely notice of plan coverage and rate changes to its Subscribers under Mississippi law.

7. Centene generally sets its policy premium rates for upcoming plan years in May and June of the preceding year, and files its rates with MID on or before the deadline established annually by the Commissioner of Insurance. Centene submitted its premium rates for the current 2024 policy year by July 19, 2023, as required by the Commissioner. Premium rates for policy year 2025 were submitted to the Commissioner by July 19, 2024.

8. Centene utilizes experience rating to establish its premium rates for individual plans. Experience rating utilize historical claim and payment information for each plan to estimate anticipated future claims and payments that group is likely to experience, and uses that estimate to establish the following year's premium.

9. The process of setting premium rates is dependent on having a clear understanding of what medical services are to be considered covered benefits under a plan in the coming year, and having a known or reasonably estimable "allowable" for covered services. Without a clearly defined description of precisely what claims will be covered by a plan, Centene cannot utilize its historical claims data to reasonably estimate the total number, frequency or type of covered claims it is likely to experience in the coming plan year. Furthermore, without a known or reasonably estimable allowable to be paid for certain covered claims, Centene cannot reasonably estimate anticipated plan reimbursement costs. Without clearly defined covered benefits and known or reasonably estimable reimbursement rates, Centene's ability to set plan premiums that are reasonably priced for its Subscribers to account for likely plan costs will be severely hampered.

10. I am familiar with House Bill 1489, the statute at issue in this lawsuit. As part of my job duties for Centene, I am familiar with the process used by Centene to estimate premiums for plan year 2024, which were determined in 2023 and filed with the Commissioner by July 19, 2023, and for plan year 2025, which were filed with the Commissioner by July 19, 2024. The

mandatory reimbursement language in Section 2 has created significant impacts to Centene's plans currently in effect, and created significant uncertainties that impacted the premium rate setting process for plan year 2025.

11. With respect to setting premium rates for plan year 2025, Centene is not aware of the terms of any ambulance service providers' contract with counties, municipalities or special purpose districts or authorities that provide agreed upon rates for their residents. To the extent any ambulance company has entered into such special rate contracts, this information is not available to Centene and has not historically been provided to Centene. Additionally, Centene was unable to locate any such contracts being publicly available to it as it went through its process of evaluating and determining premium rating in July, 2024, for purposes of filing its proposed 2025 premium rates with the Commissioner by July 19, 2024. Even if such special rates with government entities exist and the special rate information had been available, the sheer number of these contracts and the burden of collecting the rates would make a review and pricing analysis nearly impossible. Even if Centene did know these rates, the payment configuration for each provider would be extremely difficult. As an example, Centene has 14 distinct Ambulance providers in Magnolia's network. These providers service all 82 counties in Mississippi, with multiple municipalities within each county. Depending on whether contracts exist with the separate municipalities within each county, there could be anywhere from 3,000-5,000 separate pricing arrangements to determine in the state. Even assuming each ambulance service provider separately contracts with a county or municipality, this makes it nearly impossible to reasonably estimate anticipated charges to set reasonable rates for future plan years.

12. Centene was able to determine the 2024 reimbursement rates for out of network ambulance service providers established for Medicare by the Centers for Medicare and Medicaid

Services ("CMS") applicable to region 07302, which covers Mississippi. CMS reimbursement rates depend on the nature of the ambulance service provided and claimed based on up to nine (9) Current Procedural Terminology ("CPT") codes, ranging from a low reimbursement of $0.00 for some services to a high reimbursement of $817.51 for other services. Without knowing the specific ambulance services required to be covered by House Bill 1489, it is difficult to identify which CMS reimbursement rates may be applicable to the calculation called for in Section 2. However, an allowable reimbursement rate of 325% of the CMS reimbursement rate would be significantly higher than the current allowable under Centene' plans.

13. Section 2 of the Bill provides that Centene must reimburse out of network ambulance service providers the amount of their billed charges if that amount is greater than (a) contract rates agreed to with counties, municipalities or special purpose district or (b) 325% of CMS' rate. I have reviewed claims data for ambulance service claims filed for dates of service in 2023 and the first six months of 2024. During that 2023, claims for reimbursement including more than 162,000 CPT codes were filed by ambulance service providers. The 2023 claims data reflects that the average billed charges received per CPT code differ from the Medicare rate by a range of 232.82% to a high of 494.55%. However, the highest billed charges received per CPT Code, which Section 2 requires to be paid, differ from the Medicare rate by a range of 809.70% to a high of 1,582.25%. During the first six months of 2024, claims reflecting more than 57,000 CPT codes were filed. During this time, the average billed charges received per CPT code differ from the Medicare rate by a range of 284.79% to a high of 620.73%, and the highest billed charges received per CPT Code differ from the Medicare rate by a range of 284.79% to a high of 1,393.15%. For ambulance claims filed between July 1, 2024 and July 22, 2024, average billed charges received per CPT code differ from the Medicare rate by a range of 310.25% to a high of 634.92%, and the

highest billed charges received per CPT Code differ from the Medicare rate by a range of 631.04% to a high of 1,393.15%.

14. Centene's premium rates currently in place for the current 2024 plan year were established in 2023 and filed with the Commissioner by July 19, 2023. Centene did not and could not anticipate the legislature would pass legislation requiring reimbursement of out of network providers at amounts up to their full billed charges. These premium rates were established based on Centene's estimation of claim costs taking into account claims history and payments at its contract allowable rates in its plans approved and issued effective January 1, 2024, which rates were materially lower than 325% of CMS' reimbursement rates. Requiring Centene to begin reimbursing out of network ambulance service providers at rates up to their billed charges on and after July 1, 2024, will result in costs significantly higher than Centene estimated when it filed its 2024 premium rates.

15. Furthermore, in future years, a requirement to reimburse certain providers at whatever amount they decide to bill will greatly impact Centene's ability to reasonably estimate premiums. Centene is committed to providing affordable health care coverage for its Subscribers and to use its best efforts to accurately estimate reasonable premium rates, but Section 2 of the Bill will impose a significant negative affect on its ability to do so.

16. A larger concern to Centene is the financial impact Section 2 will have on its Subscribers. Like other health insurance companies, Centene's plans include a patient responsibility portion for each claim which Subscribers are responsible for paying, including co-insurance. The amount of co-insurance Subscribers are required to pay is 40% of the plan allowable. Thus, in addition to potential premium increases, by requiring a plan to increase its allowable up to any amount an out of network ambulance service provider decides to bill, Section

2 also increases the amount of the co-insurance Centene Subscribers will be required to pay out of pocket. Neither Centene nor its Subscribers could have anticipated this change when the plan was issued on January 1, 2024.

17. I am familiar with House Bill 1489, the statute at issue in this lawsuit. As part of my job duties for Centene, I am familiar with the process of evaluating the terms of the Bill to determine what ambulance services were required to be included as covered benefits in health benefit plans. In my position with Centene, I routinely work to help develop medical policies, claim filing guidelines and claim processing guidelines for use in adjudicating claims submitted by providers and reimbursing for covered services pursuant to plan terms.

18. Processing and adjudicating insurance claims involves an intricate procedure. Providers submit claims to Centene utilizing standardized claim submission forms on which providers identify specific services they provided to Subscribers. Centene utilizes claim processing guidelines to clearly define what medically necessary health care services are covered under its benefit plans, how claims for those services are to be processed and adjudicated, what the patient responsibility portion of allowed covered charges will be, and how much is to be reimbursed by the plan. Ambiguity in what services require coverage render it impossible to prepare meaningful and useful claim processing guidelines. Because of the ambiguity in Section 1 of the Bill, Centene cannot determine precisely what services must be covered, and therefore, is hampered in preparing medical policies, claim filing guidelines and claim processing guidelines to ensure compliance with the law or to adequately inform its Subscribers and providers of covered benefits.

19. The Bill's definition of "alternative destination" is particularly ambiguous and has caused significant confusion in attempting to formulate guidelines. Section 1 references

emergency-type services are required, including in the definition of "ambulance service providers" and by requiring an enrollee call for potential emergency services to trigger coverage of transportation to an alternative destination. However, by defining it as a "lower-acuity" facility providing "medical services," and using "including but not limited to" specific examples to include non-emergency facilities, Centene is unable to decipher the types of facilities intended. It is substantially unclear, and Centene is unable to determine, if an "alternative destination" is intended to include medical providers who do not provide any degree of emergency medical services, or if coverage is required at the advanced life support rate to transport an enrollee to their personal physician or favorite clinic for routine, non-emergency care at the enrollee's request.

20. It is also substantially unclear whether an enrollee can choose whether he or she is taken to an "alternative destination" over a hospital's emergency department and, if so, whether he or she can choose among the seemingly unlimited types of "alternative destinations" as his or her preferred destination. Centene is unable to determine from the Bill whether a Subscriber must be afforded coverage when choosing to be transported to his or her personal physician or other preferred destination located in other municipalities and/or counties, while bypassing closer "alternative destinations." If the Subscriber is not authorized under the Bill to make the determination, it is substantially unclear who decides and what that decision must be based on. These determinations are critical to analyzing whether any particular ambulance transport is medically necessary and/or consistent with Centene's medical policies, yet the Bill is unclear on these matters.

21. Additionally, Centene cannot clearly distinguish between the requirements to cover ambulance services of "treat or assess an enrollee in place," "triage" (without transport), and for

"[a]n encounter between an ambulance service and enrollee that results without transport of the enrollee," and the Bill does not define any of these terms to afford any guidance.

22. The Bill requires coverage for any "encounter between an ambulance service and enrollee that results without transport of the enrollee." The term "encounter" is undefined in House Bill 1489, and Centene is unaware what level of service an ambulance service provider must actually provide to an enrollee, if any at all, to trigger coverage. Without a transportation requirement, Centene is unaware of how any "encounter" will require emergency ambulance services such that coverage is required. Centene also cannot determine how the term "encounter" differs from the Coverage Mandate's requirement to provide coverage for an ambulance service provider to "assess" a subscriber/insured, or the difference, if any, between the requirement to provide coverage to "assess" and "triage" a subscriber/insured, as House Bill 1489 provides no guidance or standard whatsoever.

23. The healthcare industry utilizes nationally adopted and standardized CPT codes created and maintained by the American Medical Association to identify the services provided. Providers use CPT codes to identify the specific services provided, and Centene use CPT codes submitted to evaluate available coverage and compliance with plan terms. I am not aware of any CPT code that an ambulance service provider or Centene may use when the ambulance service provider merely "encounters," "assesses," or "triages" a Subscriber. The lack of CPT code, coupled with the Bill's vague language make it impossible for Centene to consistently assess whether benefits are available for these services. Because the Bill's terms are vague and undefined, Centene cannot look to ordinary procedures, including CPT codes, to process claims.

24. Further, based on the definition of "911 call" in the Bill, Centene cannot decipher whether coverage for ambulance services and transportation at the advanced life support rates

would be triggered when a caller contacts an ambulance service directly, not through a governmental E-911 service. Centene employees must have clear guidelines to determine whether benefits are available for a claim. Without clarity on whether a call to a local government's E-911 service is required, Centene is unable to draft medical policies that comply with the mandates of House Bill 1489 with certainty. Centene is unable to decipher whether ambulance services must be triggered by contacting a local government's E-911 service for coverage to apply.

25. In short, if a Subscriber or an ambulance service provider were to contact Centene to inquire what benefits are available for ambulance services referenced in Section 1 of the Bill, Centene would be unable to meaningfully provide a response.

At this time, I have nothing further to say.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the law of the United States of America that the above is true and correct to the best of my knowledge and belief.

Dated: July 30th, 2024.

Aaron Riley Sisk