COLLEGE of AMERICAN PATHOLOGISTS

February 19, 2016
Teresa D. Miller, Commissioner
Pennsylvania Department of Insurance
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120

*Re: Points of Concern and Opposition to the Balance Billing Legislation Proposed Draft of the Department of Insurance- 01-19-16*

Dear Commissioner Miller:

The College of American Pathologists (CAP) and the Pennsylvania Association of Pathologists (PAP) are submitting the following comments in strong opposition to the above referenced draft legislation to prohibit balance billing of patients by out-of-network physicians. The CAP is a national medical specialty society representing 18,000 physicians who practice anatomic and/or clinical pathology. The CAP members practice their specialty in clinical laboratories, academic medical centers, research laboratories, community hospitals and federal and state health facilities. The PAP is a state medical specialty society representing many practicing pathologists in the State of Pennsylvania. The following sets forth our points of concern and opposition to the proposed legislation.

## I. Insurance Department Testimony of October 1, 2015 Undercuts the Rationale for the Draft Legislation

Carolyn Morris, Pennsylvania Department of Insurance, Director, Bureau of Consumer affairs, in a public statement presented at the October 1, 2015 hearing of the department, noted that the Department on average "investigates and responds to 15,000 written insurance complaints each year." Furthermore, according to Ms. Morris, "when adding in telephone calls, the number of complaints and inquiries increases to over 70,000 annually." However, Ms. Morris testified that of these reported tens of thousands of complaints each year the department has "heard from dozens of consumers" regarding issues of balance billing. Ms. Morris further elaborated that in these dozen or so cases, consumers "followed the rules of their health plan by using participating doctors, surgeons, and hospitals only to learn that an anesthesiologist, radiologist, pathologist or other provider not participating in their health plan's network provided treatment." Given that by the Department's own forthcoming account, the issue of balance billing represented a minuscule, if not insignificant, number of the complaints annually received by the Department, we question the Department's judgment and bias in seeking to promote this legislation. Such judgment is especially questionable given that the proposed bill would fundamentally alter the marketplace pricing contracted for the provision of physician's services in favor of health plans. Quite simply, the Department's position does not appear to be statically driven by consumer or patient concerns.

## II. The Proposed Bill Would Have the Effect of Discouraging Health Plans to Maintain Physician Network Adequacy TO the Detriment of Health Plan Enrollees

Pennsylvania Health plans are not currently subject to rigorous Insurance Department oversight of network adequacy for hospital-based physicians, including pathologists. This lack of regulatory scrutiny is of especial concern, as there has been a widely observed national trend of health plans intentionally narrowing health plan provider networks, by excluding certain providers and hospitals from being participating providers. When physicians, including pathologists, are excluded from participating provider status, patients are more likely to encounter out-of-network balance billing

situations. The proposed legislation eschews this fundamental concern of consumers, to have reasonable access to in-network providers, and instead incentivizes health plans to narrow networks by limiting the financial risk to consumers from these out-of-network bills. Specifically, the bill states, "an out-of-network facility-based practitioner or affiliated provider may not advance to collections any charges other than any in-network cost sharing amount that the covered person has failed to pay." In lieu of collecting from the patient, the physician provider would be limited to an undetermined percent of Medicare or the health plan's median amount for such services paid by the plan when rendered by an in-network provider. If no agreement is reached, the disagreement over payment would be submitted to an "arbitrated dispute resolution process."

The net effect of the legislation is to tip the equilibrium of payment negotiations between the health plan and the physician provider in favor of the health plan. Given this dynamic, this legislation, if enacted, would be a strong incentive to health plans regulated by the State to reduce, limit or otherwise dismantle their physician provider network in order to secure maximum economic advantage over the amount paid to physician providers, whether in-network or out-of-network.

We reject the approach of the Insurance Department which favors insurance interests. We believe that Pennsylvania patients are best served when health plans are compelled by the State to undertake their fiduciary responsibility to their enrollees to ensure that patients at in-network facilities are able to have reasonable access to in-network providers. We therefore favor regulatory or legislative initiatives that compel health plans to document to state insurance regulators that they have sufficient numbers of pathologists and other hospital based physician providers at in-network facilities.

## II. The Draft Legislation is Technically Flawed

Not only do we fundamentally oppose and challenge the intent and premise of the legislation, from a technical perspective the draft legislation fails to take into account the following scenarios:

1) patients who voluntarily select out-of-network physician providers at in-network facilities;
2) patients who have no reasonable access to in-network physician service at an in-network facility as the result of the health plan's nonfeasance;
3) health plan responsibility for notifying patients of in-network physician options and financial risk associated with out-of-network services;
4) facility responsibility for alerting patients to the financial risk of out-of-network services;
5) health plan responsibility for monitoring and reporting the Department of Insurance enrollee access to in-network physician services at in-network facilities; and
6) payment for out-of-network physician services that are covered and paid for under enrollee health plans coverage, but not covered under the Medicare fee schedule and thus cannot be calculated based upon the legislation's contemplated use of this fee schedule.

All of these aforementioned issues constitute serious lapses in the proposed legislation that are omitted from consideration and not conceptually addressed in any fashion.

## IV. Summary

For these aforementioned reasons, we urge the Department to not move forward with this legislation, and instead adopt by regulation network adequacy standards that:

- Require that health plans document to the Department that they have contracted with sufficient numbers of in-network physicians, including pathologists at in-network facilities in order provide their enrollees with reasonable access to in-network physician services, including pathologists;
- Ensure enrollees are advised by health plans and network facilities of their financial risk in receiving out-of-network physician services for scheduled in-network facility procedures;

- Ensure enrollees are advised by health plans of their options to obtain in-network physician services at in-network facilities before a scheduled procedure is to occur.

Thank you for your courtesies and consideration of these comments.

Sincerely,

Richard C. Friedberg, MD, PhD, FCAP
President

cc : Nancy Young, MD, FCAP, President Pennsylvania Association of Pathologists
Barry R. Ziman, Director, Legislation & Political Action, College of American Pathologists