Submission of the Massachusetts Society of Pathologists

To the Massachusetts Special Commission on Provider Price Variation

January 19, 2017

The Massachusetts Society of Pathologists (MSP) welcomes the opportunity to comment on the issue of out-of-network balance billing. The nature and extent of the problem of out-of-network balance billing has not been established in Massachusetts. It should be noted that the national Blue Cross/ Blue Shield Executive Director recently stated (October 13, 2016) at a Brookings forum on this issue that "there is a dearth of evidence" and "the problem at least as I see from the evidence cited to date has yet be explicated very rigorously or comprehensively." This is one area where we concur with Blue Cross/Blue Shield in that more information and analysis is needed to determine both the scope of the problem and appropriate solutions. Consequently, we respectfully suggest that the Commission's recommendations not address the issue, and, instead, we ask that the matter be referred to the legislature's Joint Committee on Health Care Financing, which will have at least one bill on this topic in the 2017-2018 session.

Intuitively, we know there is a fundamental correlation between out of network balance billing and health plan network adequacy. When regulators approve health plans that do not have hospital based physicians under contract, patients of these facilities are likely to have out of network charges. It is logical that enrollees with health insurance plans providing robust network adequacy, including hospital based physicians, have fewer bills for out of network services. Thus, the problem of out of network billing will only be exacerbated by the failure of regulators and health plans to ensure physician networks at in-network hospitals and facilities. Another factor exacerbating patient reliance on out-of-network (OON) physicians at in-network facilities is the deliberate narrowing of insurance networks by health plan payers.

> "Second, under existing market forces, provider networks are becoming narrower, creating more situations where patients encounter a mix of network and non-network providers. This is particularly the case in the non-group (individual) market, where narrow networks are especially pronounced as a result of competition on premiums for cost-conscious consumers (Cousart 2016; Bauman 2015; Polsky 2015), though network narrowing is also seen to some extent in the group market (Kaiser Family Foundation 2015)."[1]

Current American Medical Association (AMA) Policy on Network Adequacy (H-285.908.11) states: "Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties, (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible."

Accordingly, health insurance plans should be scrutinized by state insurance regulators, prior to approval, to ensure that such plans are capable of providing their enrollees with

[1] "Solving Surprise Medical Bills," Center for Health Policy at Brookings, A Brookings Institution-USC Schaffer Center Partnership, Mark Hall, Paul Ginsberg, Steven Lieberman, Loren Adler, Caitlin, Caitlin Brandt, Margaret Darling, October 2016

reasonable and timely access to in-network physician specialties at in-network hospitals and facilities.

When health plan enrollees purchase health insurance products that list in-network hospitals and facilities, but such plans have failed to contract with certain essential hospital based physician specialties at these locations, the health plan has deceived the enrollee into purchasing an insurance product that is fundamentally deficient. Such deceptive trade practices should be subject to state sanction.

Of related concern regarding the conduct of health insurance plans, some payers construe any physician waiver of co-payments, co-insurance, or deductibles whether occurring up front at the time of medical services or after receipt of payment by the plan, on any patient claim, regardless of the patient's economic status, as a potentially fraudulent activity by the physician. It has been noted in the legal community that "…the practice of out-of-network providers waiving copayments and deductibles has continued and is occurring with such frequency in the market that one national insurer in particular has resolved to commence a major legal campaign to curtail the billing practice."[2] Furthermore:

> A provider may receive significant legal protection similarly by including a statement on its insurance claim that it will waive the copayment or deductible, or that it reserves the right not pursue the patient for these amounts. This disclosure, however, could result in the insurer's denial of the claim, and if the insurer does not agree to the statement, a provider risks displaying the requisite intent for being accused of insurance fraud.[3]

Nevertheless, according to a recent national survey, approximately 22% of individuals who used OON providers negotiated an OON bill with the insurer or provider, and <u>58% were successful in reducing their costs for at least one of the bills.</u>[4]

Health insurance plan efforts to legally assail physician authority to waive charges, on a case-by-case basis, based upon a patient's economic condition, creates a hostile legal atmosphere that is designed to deter such benevolent financial actions by physicians for their patients. Accordingly, physicians should have an explicit legal safe harbor in state law to conduct such waivers on out-of-network charges on a case by case basis so as to financially benefit economically distressed patients.

The issue of out-of-network balance billing is multi-dimensional. Simplistic solutions that favor health insurance plans with governmental price setting for out-of-network physician services would, and should, raise questions about the fundamental purpose and need for health insurance plans if they have no financial incentive, nor legal obligations, to contract for physician services.

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[2] "Out of Network Referrals and Waiver of Patient Copayments and Deductibles: The Battle Between Payors and Providers Endures and Intensifies," <u>The Health Lawyer</u>, Charles C Dunham, Esq. O"Connell & Assoc. Albany, NY., Volume 25, Number 5, June 2013.
[3] Ibid.
[4] "Patient's Success in Negotiating Out-of-Network Bills," <u>The American Journal of Managed Care,</u> Kelly A. Kyanko, MD, MHS, Susan H. Busch, PhD, Vol, 22, No 10, October 2016.

The non-partisan National Association of Insurance Commissioners (NAIC) in its annotations on this issue (MDL 74-22) noted that states should consider a payment formula such as: “a) some percentage of a public, independent database of charges for the same or similar services in the same geographic area, or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation.” Importantly, the NAIC notes the imperative need for states to recognize the need for payment equilibrium in the market:

> “In setting a benchmark or benchmarks state should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility based providers and heath carriers to agree on a contract.”

It is the position of the Massachusetts Society of Pathologists, and the College of American Pathologists, that patients are best served by insurance products that provide in-network services through the continuum of care that an enrollee is likely to need and receive in the hospital setting. Health policy measures that do not compel health plans to contract for the provision of such services for their enrollees alter the public policy rationale for participating provider (PPO) insurance products and should raise fundamental questions about the role of insurance in the value chain of health care delivery.

Thank you for your consideration.