Pennsylvania Association of Pathologists

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June 1, 2017

Senator Don White, Chairman
Banking and Insurance Committee
Pennsylvania State Senate
286 Main Capitol
Harrisburg, PA 17120

Re: Opposition to Senate Bill 678 (Out-of-Network (OON) Payment)

Dear Chairman White:

The Pennsylvania Association of Pathologists (PAP) is submitting the following comments in strong opposition to the above referenced legislation to prohibit balance billing of patients by out-of-network physicians. 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 Senate legislation.

I. The Rationale for the Legislation Has Not Been Established and the Design of the Legislation Would Financially Benefit Health Insurance Payers

There is no evidence that balance billing is a significant policy issue of concern in Pennsylvania. Last year, the Pennsylvania Insurance Department publicly reported in testimony 35 balance billing complaints out of a total of 75,000 insurance complaints. It should be noted that even the national Blue Cross/ Blue Shield Executive Director recently stated (October 13, 2016) at a national forum on the issue of out-of-network balance billing that "there is a dearth of evidence" and "the problem at least as I see from the evidence cited to date has yet to be explicated very rigorously or comprehensively."

Scenarios that create balance billing usually occur as the result of failure in health plan network adequacy at hospitals and facilities where patients cannot access in-network providers. Accordingly, we believe the primary, if not exclusive, purpose of any proposed Pennsylvania law to address out-of-network billing should be the regulation of health plans to ensure that such plans can provide the full continuum of in-network patient care at in-network hospitals and facilities.

Specifically, In lieu of a ban on balance billing, the legislation should be limited to: 1) network adequacy requirements that the Department of Insurance should enforce against health insurance plans to ensure that they contract with hospital-based physicians; and 2) the application of unfair trade practice penalties against health plans that deceptively market health insurance products as having in-network hospital and facilities without providing medically necessary hospital-based specialties under contract.

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II. The Legislation Is Flawed In Its Construction

Section 303 (Page 11, Line 29) expressly prohibits an OON provider from sending a "surprise bill" to a patient in excess of the in-network cost sharing amount applicable to the patient. Nevertheless, Section 303 (Page 12, Line 21) addresses scenarios wherein patients receive a "surprise bill," which appears to be inconsistent with the provision that precludes such billing.

This Section should, but does not, exclude OON providers that have furnished services when the patient had the opportunity to select an in-network provider, but failed to exercise the option. If a patient has the "control and ability to select an in-network provider," such patient should not be financially disincentivized from that selection. If patients have no financial incentives to select in-network providers over out-of-network providers, there will likely be efforts by health insurance carriers to systematically dismantle physician networks to the detriment of health care delivery.

The bill also does not require health insurance carriers to execute timely transmission of any "Explanation of Benefits" to the OON provider, nor conspicuously identify for the OON provider whether the plan is constituted under federal ERISA law and thereby exempt from the purview of the legislation.

III. The Legislation Fails to Safe-Harbor Physician Waiver of Out-of-Network Charges.

According to a recent national survey, approximately 22% of individuals who used OON providers negotiated an OON bill with the insurer or provider and 58% were successful in reducing their costs for at least 1 of the bills.[1] For those patients seeking a change in the bill, **sixty-three percent (63%) were successful in reducing their bill when conferring with the OON provider.**

Nevertheless, some health insurance plan payers expressly construe any physician waiver of co-payments, co-insurance, or deductibles on any patient claim, regardless of the patient's economic status, as a potentially fraudulent activity by the physician. 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 bill does not confer any statutorily protected discretion on physicians to waive charges based upon patient economic necessity.

[1] "Patient's Success in Negotiating Out-of-Network Bills," The American Journal of Managed Care, Kelly A. Kyanko, MD, MHS, Susan H. Busch, PhD, Vol, 22, No 10, October 2016.

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OON payment legislation should expressly allow physicians to waive OON charges based upon patient economic necessity. Specifically, to benefit patients: "Any out-of-network provider who, on a case by case basis, determines to waive any cost for an enrollee in a health plan based upon economic circumstances of the enrollee, including any balance billed amount, co-payment, coinsurance or copayment, shall not be subject to: 1) any civil cause of action by a health plan; (2) subject to prosecution for any violation in any court of jurisdiction, or (3) any sanction before any state oversight board (4) any approval requirement of a health plan."

IV. The Legislation Fails to Recognize "Usual and Customary Charges" Used by Health Insurance Companies for OON Payment

The legislation provides payment parameters (Page 19 Lines 1 through 27) to be used by an Arbitrator but does not include consideration of "usual and customary charges" as determined by an independent database of charges. Specifically, the legislation should include in the parameters for the Arbitrator's recognition of: "a usual, customary and reasonable rate meaning the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization specified by the Insurance Commissioner. Such organization shall not be affiliated with any health carrier."

Documents and information from multi-state offerings of Aetna and United Healthcare indicate that these plans, to some extent, avail the 80th percentile of the Fair Health Inc. charge database for calculating OON payment. While these payors have vigorously fought against state codification of this payment methodology, we believe that their current use of this methodology reflects the suitability and appropriateness of this payment formula. Quite simply, health plan efforts to resist codification of this 80th percentile formula are a misleading deflection from current payment practices reflecting the true market value of physician services.

Moreover, it should be noted, that the State of New York, in 2014, enacted this 80th percentile of charges formula for out-of-network (OON) payment with no reported adverse impact on the health insurance market. Specifically, under New York law to govern OON payment, "usual & customary" (as defined in statute as the 80th percentile of billed charges as calculated by an independent database) is one of the standards for dispute resolution on any OON bill. In addition, NY requires all health plans offering OON coverage to offer one insurance option that covers OON services at the 80th percentile of an independent charge database (i.e. Fair Health Inc.).

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For all of these aforementioned reasons, we are opposed to the legislation and look forward to continued discussion. We greatly appreciate the opportunity to comment on the legislation.

Sincerely,

Jasvir S. Khurana, MD
President

cc: Mr. G. Carlton Logue
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