MASSACHUSETTS SOCIETY OF PATHOLOGISTS, INC

June 14, 2017

Senator Karen Spilka, Chair
Senate Committee on Ways & Means
State House, Room 212
Boston, MA 02133

Representative Brian Dempsey, Chair
House Committee on Ways & Means
State House, Room 243
Boston, MA 02133

Re: Senate Sections 10, 98, 127, 128, 129, 130, 183, 183A, 184, 184A, 251, 261, 262 regarding Unavoidable Out of Network billing

Dear Chairwoman Spilka and Chairman Dempsey:

I am writing on behalf of the Massachusetts Society of Pathologists and the College of American Pathologists to express our opposition to the sections of the proposed Senate budget listed above regarding out of network billing.

The Provider Price Variation Commission's recent report called upon the Health Policy Commission to convene a workgroup to consider proposals for how to address the medical bills patients receive when they are treated at an in-network hospital by providers who are, unbeknownst to the patient, out of network or when they have been taken to an out of network hospital in an emergency. In each of these cases, the patient could not choose between in network or out of network physicians. The workgroup is expected to make recommendations to the legislature to inform its deliberations on this issue. The Massachusetts Society of Pathologists looks forward to participating in this workgroup if asked to join it and certainly to assist as it wrestles with this challenging and complex issue. MSP believes the appointment of a workgroup where all stakeholders can work out a proposal is a wiser course of action than trying to address this policy matter in the state's fiscal year 2018 budget.

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The Need for Network Adequacy:

We believe that patients are best served by insurance products that provide in-network services through the continuum of care that a patient is likely to need and receive in the hospital setting. Robust networks are the most effective way to reduce the likelihood of a patient receiving a bill for out of network services received at an in-network hospital.

When regulators approve health plans that do not have hospital based physicians under contract, patients utilizing these hospitals 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 adequate physician networks at in-network hospitals and facilities.

If Massachusetts is determined to regulate health insurance plan payment for out of network services provided in the hospital setting, the state should recognize that physicians, including pathologists, cannot exercise discretion in the performance of these services. For the most part, pathologists are under legal and ethical obligations to perform these services when specimens are referred within the hospital setting, whether or not the pathologist has a contract with the patient's health insurance plan. Accordingly, hospital based physicians should not be financially penalized, and payment for such services should reflect the market value of physician services.

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 out of network payments. 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 payment with no reported adverse impact on the health insurance market. Specifically, under New York law governing out of network payments, "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 out of network bill. In addition, New York requires all health plans offering out of network coverage to offer one insurance option that covers out of network services at the 80th percentile of an independent charge database (i.e. Fair Health Inc.).

We favor market-based payment for out of network physician services that will strongly incentivize health plans to contract for the in-network provision of services, which we believe is optimal for health care delivery. Conversely, out of network payments to physicians that are below market rates inherently favor health insurance payors. Any adverse payment methodology for physician services will likely lead to further narrowing or dismantling of physician networks, with the inevitable result of shifting these out of network costs to enrollees.

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Moreover, 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. We strongly urge that such deceptive trade practices should be subject to state sanction.

Setting a Default Rate for Unavoidable Out of Network Bills:

The Massachusetts Society of Pathologists supports a policy that ends the problem of patients receiving unavoidable out-of-network bills. Such a policy must do three things to be successful:

1) enhance health plan network adequacy for hospital-based physician services, by requiring health plan compliance with stringent network adequacy standards for these services;
2) hold health plans financially accountable for their network failures and gaps, by ensuring an equitable and sustainable formula for payment directly to physicians providing out-of-network services to their enrollees,
3) reduce the financial risk to patients who are unable to access in-network services at in-network hospital and facilities by limiting their financial responsibility for unavoidable out-of-network bills to in-network costs, while maintaining incentives for patients to use in-network physicians when available to them.

Many out-of-network scenarios are clearly the fault of health plans with inadequate networks. In these cases, we favor both appropriate market based payment for out of network physician services and clear regulatory obligations on health plans to induce contracting for hospital-based physician services

The Senate's proposal on this topic fails to meet the first and second criteria. Specifically, the proposed default payment could have dramatic effects on the sustainability of many physician practices and health care institutions, ultimately jeopardizing access to care in many underserved areas. The Health Policy Commission would have nearly unfettered power to set rates that would be in effect for five years, with no meaningful protections for physicians against artificially low rates and no penalties on insurers that would have a financial incentive to develop highly limited networks because the out-of-network rate is to their advantage.

The implications of an insufficient reimbursement strategy extend beyond just underpayment for the current sliver of unavoidable out-of-network care. If a default rate is substantially below market value, insurers would have little incentive to negotiate in good faith with physician practices, knowing that any resulting out-of-network scenario would be reimbursed at a low default out-of-network rate. Having this insufficient reimbursement rate would significantly jeopardize the sustainability of both health plan networks and many physician practices, threatening access to care for patients across the Commonwealth.

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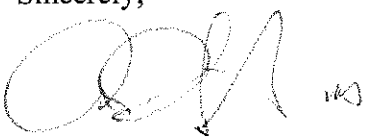
We are concerned about the impact that insufficient reimbursement formulas could have on hospitals and patients. Hospitals rely upon physician groups for the very heart of their mission. Emergency physicians, anesthesiologists, radiologists, and pathologists, among others, are the lifeblood of the hospital. If these physician groups cannot remain solvent due to lower reimbursements and unfair negotiating dynamics, hospitals will be forced to find ways to retain these services, often through subsidization of the physician practice. If these levels of subsidization increase, the sustainability of hospitals with low operating margins could be jeopardized. Such at-risk hospitals are often those that provide critical access in geographically isolated locations, often to low-income patients in need. Access to care for thousands of patients could be in jeopardy.

The Massachusetts Society of Pathologists looks forward to working with the Health Policy Commission and the legislature to seek the adoption of legislation to address unavoidable out of network billing that both protects patients and ensures physicians are paid a sustainable and equitable rate for their services.

Sincerely,



Anthony J. Guidi MD, FCAP
President

cc: Members of the FY2018 Budget Conference Committee
Senate President Stanley Rosenberg
Speaker of the House Robert DeLeo

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