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March 21, 2020

Cindy Friedman, Chair
Daniel Cullinane, Vice Chair
Joint Committee on Health Care Financing
State House
Boston, MA 02133

Re: Provisions regarding the payment for out-of-network services in H. 4134, An Act to improve health care by investing in VALUE

Dear Senator Friedman and Representative Cullinane:

The Massachusetts Society of Pathologists (MSP) supports revision of the state law[1] that currently holds a patient financially harmless for an out-of-network bill for care received at an in-network facility when the patient did not consent to such out of network services. Specifically, we support adding an explicit ban on balance billing in situations in which a patient cannot access an in-network provider, because of the failure of his/her insurance plan to offer an adequate network, and the patient has not voluntarily selected an out-of-network provider.

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[1] In 2012, the legislature passed M.G.L. chapter 176O, section 6(a)(4) making clear that patients who receive care from an out of network doctor at an in-network hospital are not responsible for paying out of network rates unless they voluntarily elect to be treated by an out of network physician. When unavoidable out of network care occurs, the patient's insurance company must pay the higher, out of network rate. The patient is only responsible for his or her usual deductible or co-pay.

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It is our view that patients should not be held financially responsible for the contractual failures of their insurance plans to provide timely access to in-network physician services. It is critically important that health plans have a clear and compelling regulatory and economic incentive to contract with physician specialists, including pathologists. For these reasons, we have strong objections and concerns regarding H. 4134, An Act to improve health care by investing in VALUE, filed by Governor Baker.

I. **The legislation establishes an arbitrary out of network payment amount at an undefined percent of Medicare that is to be exclusively determined by the administrative fiat of the Health Policy Commission.**

The legislation confers arbitrary and excessive discretion on the Health Policy Commission to use Medicare as a benchmark for out of network payment amounts. According to the American Hospital Association (AHA), at a national level the disparity between the cost of providing Medicare hospital services for patients and the actual payment for such services was negative $53.9 billion. AHA has determined that in the Medicare program, hospitals received payment of only 87 cents for every dollar spent by hospitals caring for Medicare patients in 2017. In 2017, AHA estimates that 66 percent of hospitals received Medicare payments less than cost. The untenable gap between these payment levels and the cost of services provided in the hospital setting is largely defrayed by private health insurance.

Medicare is an inappropriate benchmark for payment by commercial insurers, and it would have dramatic adverse effects on the sustainability of many physician practices and health care institutions, ultimately jeopardizing access to care in many underserved areas. We oppose the use of Medicare rates alone and unadjusted as the default for out-of-network physician reimbursement.

Medicare is not and never was intended to be a broadly applicable index for commercial physician payment. Medicare rates are not established to represent a valuation of professional services provided; instead, they function as a distribution of an already limited budget of this social service program.

More broadly, it is important to understand that 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 will 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 become an expanding portion of overall payments would significantly jeopardize the sustainability of many physician practices, threatening access to care for patients across the Commonwealth.

The contemplated delegation of this Medicare pricing authority to the Health Policy Commission, without any statutory safeguards on what is an appropriate percentage of Medicare rates, entrusts to the state bureaucracy formidable decision-making over the financial well-being of the health care system. The use of that discretion in an imprudent manner by the state bureaucracy is likely to create profound, unintended economic consequences and potential loss of patient access to high

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quality and timely diagnosis and treatment. The Massachusetts Society of Pathologists opposes changing the fundamental mission of the HPC from a policy-setting organization to a rate-setting entity. Additionally, these proposals include no sanctions on insurers that could decide to develop significantly limited networks knowing that the out-of-network rates will be favorable to them.

Specifically of concern, mandated payments at the lower range of Medicare percentages will undoubtedly lead to an adverse impact on health care delivery. Empowering non-elected state officials to exercise such controls will potentially confer on them a level of autonomy that is both without precedent in this area of physician services, and potentially unaccountable for downstream adverse consequences that will have large scale impact on Massachusetts patients.

Accordingly, in terms of an appropriate payment methodology for out of network services, the MSP has endorsed the dual pronged payment mechanism contemplated under H. 1046, as follows:

> "When an out-of-network provider, not selected by prior written consent of the insured, renders covered health care services, other than for emergency services, to an insured, the carrier shall pay that provider **the greater of**: (i) 115 per cent of the average rate the carrier pays for that service performed by a health care provider in the same or similar specialty and provided in Massachusetts, as determined by the commissioner of the division of insurance, and in consultation with the center for health information and analysis, using all payer claims data for the year 2019, adjusted annually by the growth rate of potential gross state product and (ii) 125 per cent of the Medicare rate for that service. Such payment shall constitute payment in full to the out-of-network provider for the covered health care services."

This dual pronged approach ensures that payment levels are sustained in order to maintain the financial viability of the health care delivery system, while recognizing the commercial value of physician services, including pathology services, as determined in the contracted marketplace between payers and providers. The legislation expressly ensures that out of network payment levels cannot be less than 125% of Medicare, a level which is a baseline floor also used in California in its law to govern out of network payment for non-emergency services. Without this explicit statutory safeguard, we are greatly concerned that the Health Policy Commission will establish a Medicare payment percentage that undermines the long-term financial viability of specialty physician practice and the health care delivery system.

II. Clarification Required for Provider Contracts with Carriers on Health Benefit Programs

Of additional concern, the legislation at line 3543 et. seq. would compel out-of-network providers to accept the "average contractually agreed upon amount" for any line of contractual business the provider has with the insurance carrier. It should be made clear that both Medicare Advantage and Medicaid Managed Care for purposes of calculating an "average contractually agreed upon amount" are expressly excluded from consideration as such plans could be construed as being encompassed within the current statutory definition of a "health benefit plan" (Chapter 1760 § 1).

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III. The Need for Network Adequacy

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 of 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.

When you are crafting a bill, we respectfully ask that you recognize that physicians in a hospital setting, including pathologists, cannot exercise discretion in the performance of their services. For the most part, pathologists are under legal and ethical obligations to perform 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.

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 payers. Any adverse payment methodology for physician services will likely lead to further narrowing or dismantling of physician networks.

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, these health plans have deceived the enrollee into purchasing insurance products that are fundamentally deficient. We strongly urge that such deceptive trade practices be subject to state sanction.

We support efforts to enhance health plan network adequacy for hospital-based physicians, hold health plans financially accountable for their network failures and gaps, and reduce the financial risk to patients who are unable to access in-network services at in-network hospitals. These 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 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

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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."

The Massachusetts Society of Pathologists believes 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.

IV. **The legislation contemplates a statutory impediment for community-based physicians and independent laboratories from purchasing technical component anatomic pathology services from hospitals.**

Section 64 of H. 4134 precludes community-based physicians from billing for facility fee services provided at hospital laboratories. Such services could include the technical component (specimen preparation) of anatomic pathology services. Under current law, these technical services could be procured by physicians who are performing the professional service of anatomic pathology.

Of concern, the legislation expressly states in lines 1068-1075 that:

> (b) A health care provider shall not charge, bill or collect a facility fee except for: (i) services provided on a hospital's campus; (ii) services provided at a facility that includes a licensed hospital emergency department; or (iii) emergency services provided at a licensed satellite emergency facility.
>
> (c) Notwithstanding subsection (b), a health care provider shall not charge, bill, or collect a facility fee for a service identified by the commission pursuant to its authority in section 20 of chapter 6D as a service that may reliably be provided safely and effectively in settings other than hospitals

This proposal places hospitals at a competitive disadvantage in providing certain technical services, including the technical component of anatomic pathology services. A prohibition on access to hospital-based technical component pathology services will result, in many cases, in these services being diverted to independent commercial laboratories. This statutory prohibition is not based upon any obvious public policy logic or rationale, as such commercial diversion could likely exacerbate the cost of these services.

The availability of these hospital-based technical services for use by community-based clinicians optimizes competition for these services in both quality and cost to the benefit of Massachusetts patients. Should these hospital services no longer be available in the community, the likely result is greater commercial concentration in the provision of these services by large volume commercial laboratories, which will then face less competition, resulting in increased cost and potential

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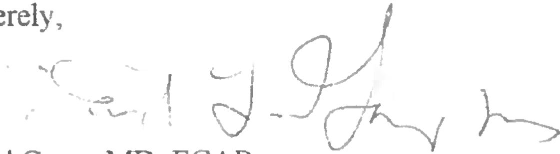
decline in quality. Thus, this provision of the bill should be modified to eliminate the prohibition on community-based physicians billing for these services rendered by hospital-based facilities.

In conclusion, we look forward to working with you to resolve these concerns and to secure legislation that protects patients while maintaining the financial viability of specialized physician services and the high quality currently afforded in the Massachusetts health care delivery system. The Massachusetts Society of Pathologists supports a policy that establishes an equitable and sustainable formula for the payment of out of network services while also providing a clear ban on balance billing.

Thank you for your courtesies and consideration of these comments.

Sincerely,



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