



COLLEGE of AMERICAN PATHOLOGISTS

February 18, 2018

The Honorable Bill Cassidy, M.D.
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Michael Bennet
261 Russell Senate office Building
Washington, DC 20510

The Honorable Todd Young
400 Russell Senate Office Building
Washington, DC 20510

The Honorable Tom Carper
513 Hart Senate Office Building
Washington, DC 20510

The Honorable Lisa Murkowski
522 Hart Senate Office Building
Washington, DC 20510

The Honorable Margaret Wood Hassan
330 Hart Senate Office Building
Washington, DC 20510

Dear Senators Cassidy, Bennett, Young, Carper, Murkowski, and Hassan:

We appreciate the opportunity to provide you data and answers to questions surrounding the issue of surprise bills. We have done our best to get you what data we have given the short time provided to us as a provider group. Unfortunately, much of the data you requested would take months to collect and synthesize. If the CAP can clarify anything or elaborate on any of our answers, please don't hesitate to contact Michael Hurlbut at mhurlbu@cap.org or 202-354-7112.

Please see the following answers to the Provider section of questions.

Provider Questions

1. *What is the average out-of-network payment that your providers receive for emergency services? How does this compare to Medicare and charges, broken down by plan type and market? How does this differ by state?*

Not Applicable to Non-Emergency Services (i.e. pathology)

2. *How does the average out-of-network payment for ancillary providers compare with Medicare reimbursement and physician charges, again broken down by plan type and market?*

We do not have information responsive to this request (i.e. pathology)



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3. *According to an article published by the Health Care Cost Institute, emergency room spending per person has increased by 98% while overall emergency room utilization remained the same between 2009 and 2016. How do you explain this trend?*

“Not Applicable” to Non-emergency services (i.e. pathology)

4. *What percentage of ER, radiology, anesthesiology, and pathology services are performed by providers that are part of outsourcing firms? For each of these specialties, what are the relative market shares for the large national staffing companies, local or regional physician groups, and hospital-staffed specialists? For providers employed by those firms, what percentage share the network status of the facility where they are practicing?*

There are no “large national staffing firms” providing pathology services. Several large commercial laboratories have a national presence and are under contract with most health plans. Hospital-based pathologists are either employed by hospitals, or under independent contract with the hospital, or affiliated with or employed by independent laboratories. According to a 2018 pathologist member survey conducted by the CAP, for nearly one-third (32.6%) of practices based in independent laboratories, pathologists were either denied continued participation in a health plan provider network or were rejected by a new health plan provider network.

5. *What percentage of amounts paid for overall emergency care, by both patients and payors, can be attributed to balance billing (dollar amounts and/or percentage amounts)? How about for other specialty departments (e.g. anesthesiology, radiology, pathology, etc.)? If possible, please provide data showing the amounts (or percentages of overall emergency care) paid for services by out-of-network providers at in-network facilities, as well as in-network providers at out-of-network facilities. If possible, please provide data to compare private versus public payments in these scenarios. Please also provide a breakdown of surprise medical bills attributable to each provider specialty.*

According to 2016 published data, for enrollees with large employer group coverage, the percent of outpatient service days that include a non-network pathology provider at an in-network facility is 10.6%¹

¹ Kaiser Family Foundation Analysis of Truven Market Scan Data from large employer health plans, August 13, 2018



6. *In situations where the ED or ancillary physician is out-of-network but the facility is in-network, can you provide data to show how often a balance bill is sent to the patient?*

According to a statistical analysis by Garmon and Chartock, the rates of surprised medical bills from pathologists declined by approximately 50% between 2007 and 2014. This decline included elective in-patient services paid out-of-network from 11.6% to 4.8%.²

7. *What percentage of care provided in the emergency department results in bad debt from patients not paying their part of what is owed from care they received, from missed copayments, denied claims, or other means?*

Not Applicable to Non-Emergency Service (i.e. pathology)

8. *What specific recommendations do you have to facilitate in-network contracting between providers and plans in the context of federal legislation to address surprise medical billing?*

We support federal enactment of network adequacy requirements similar to the law of Louisiana (Network Adequacy Act 22§1019.1 et seq.) that expressly requires health insurance plans to “maintain a network of providers that includes but is not limited to providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers.” Facility-based physicians are defined in the Louisiana Act to include: “anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician, who is required by the base health care facility to provide covered health care.” Such requirements should be subject to regulatory oversight and enforcement to ensure that enrollees (patients) have reasonable and timely access to in-network physician specialists at in-network hospitals and facilities. California (Code of Regulations (CCR) Title 10, Section 2240.5 (d) (14)) and New Hampshire (RSA 420.J:7 II(e)) are two other states with specific hospital-based physician network adequacy requirements. However, at present, the vast majority of states have no such hospital-based physician network adequacy requirement and thus should be compelled under federal law to adopt such requirements.

² Garmon C. Chartock B. “One in Five Inpatient Emergency Department Cases May Lead to Surprise Medical Bills” Contact CGARMON@FTC.GOV, Published on-line December 14, 2016.



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9. *What percentage of care provider by providers within each specialty is out-of-network? Broken down by each specialty, what share of providers are out-of-network for 0-10%, 10-25%, 25-50%, or more than 50% of the commercially insured patients (not including Medicaid managed care) they see?*

We do not have information responsive to this request (i.e. pathology)

10. *Can you identify specific states where providers have a lower-than-average contracting rate?*

It is important to recognize that the vast majority of providers, including pathologists, wish to contract with health plans. Health plans have deliberately and systematically denied network participation to, or ejected pathologists and clinical laboratories from network participation. This intentional health plan business practice of “narrowing” health plan provider networks is well-documented.

When queried by the legislature, the Texas Department of Insurance (TDI) reported in a public hearing in May of 2016 that, for the entire State of Texas, only three (3) physician providers had refused to contract with health plan payers in the State of Texas, according to information provided to the TDI from the insurance plans they regulate. However, in Texas, the Center for Public Policy Priorities reported in 2014 that one health plan in the state had no pathologist providers at 20% of their in-network hospitals. Clearly, this failure to contract is by the intentional design of the commercial health plan. Most recently, in October 2018, this particular health plan was fined \$700,000 by the Texas Department of Insurance for failure to contract with a hospital-based physician specialty in multiple counties

11. *What role do you think that hospitals should play in combatting surprise medical billing?*

Hospitals should, to the extent practicable, provide in-network physicians for patients if such physicians are available at the facility. Hospitals can facilitate contracting by applying pressure on health plans to contract with physicians. Similarly, hospitals should strongly encourage physicians to contract when reasonable contracting terms are offered by health plan payers. However, hospitals do not have and cannot have legal authority to compel or coerce contracting as such activities would be contrary to well established, fundamental principles of common law that holds contracts as voluntary exercises by both parties and that contracts made under duress are not valid legal instruments.



12. In your view, is there a state model that has worked particularly well at protecting patients from surprise medical billing? If so, why has it worked well? Please provide the details of this model, including its impact on contracting rates and out-of-network payment rates, and describe the data and policy rationale underlying this state legislation.

There are several states that have policies that protect patients from out-of-network bills resulting from gaps in health insurance plan contracting. States with laws that are reasonable and that appropriately protect patients include: Arizona, New Jersey, Maryland, Massachusetts, Illinois, Minnesota, Florida, Colorado, New Hampshire.

In our view, the optimal state law protecting patients from surprise medical billing is the law enacted by New York State. Not only is there mediation/arbitration between insurers and providers, but the payment methodology upon which the “usual and customary rate” (UCR) is calculated is based upon the 80th percentile of FAIR health database charges, so as to reflect the market value of physician services. There is a ban on balance billing patients, a way for disputes to be resolved, and it relies on a payment rate that is acceptable to the provider community.

Other states (California, Oregon, Maine, Connecticut) that have enacted laws in this area unreasonably favor the health plan insurance industry by keying rates to Medicare or to in-network amounts unilaterally under the control of the health plan, and thereby deter health plan contracting by eliminating any economic incentive on the health plan to contract for physician services.

13. What percentage of balance bills are more than \$750?

According to AHIP published 2015 data, the most common pathologist service CPT 88305 service (Tissue exam by pathologist) for 11,807 providers, billing 767,814 units of service, the average out-of-network charge submitted (2013-2014) was \$227.00.

It should further be noted that pathologists waive charges quite frequently for patients, as reported in our 2018 CAP pathologist practice leader survey:

-) 22.4% of all pathology practices reported 5-9% of their cases are charity care/uncompensated care;
-) Another 33.9% of pathology practices reported a greater than 10% charity/uncompensated care case load.

The Committee should also be aware that commercial health plans across the nation are waging a legal and policy battle to deny physicians the legal ability to waive out-of-network charges for patients, based upon the economic circumstance of the patient. For example, in Louisiana BCBS policy states: “Providers cannot



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waive the member's cost sharing obligations, such as deductibles, coinsurance (including out-of-network coinsurance differentials), penalties or the balance of the bill. A claim that is filed that includes any amounts the provider waives may be a fraudulent claim because it includes amounts that the member is not being charged and will be reduced by the total amount waived."