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Statement of the Connecticut Society of Pathologists
In Support of Senate Bill 876

Parity In Out Of Network Payment Legislation

I am here today on behalf of the Connecticut Society of Pathologists, a state-wide medical specialty society that represents many practicing pathologists in the state.

This legislation before you is needed to correct an error in the current Connecticut law that provides out of network emergency medicine with payment established at 80% of the FAIR Health Inc and all other physician services at the in-network rate of the health insurance carrier payment. This payment formula went into effect this past July. This public policy is a disincentive to health plan contracting and does not serve the patient's health care interest.

The Connecticut Out-of-Network law was modeled after a similar law in New York-- with the one glaring exception being that New York correctly provides parity for all hospital based physicians, with a payment under 80% of the FAIR Health Inc. In addition, no other state adversely differentiates payment of all other physician services from emergency medicine. This error must be corrected because:

- 1) The current law is **not transparent and is highly biased** in determining payment **because only the payer determines the in-network payment rate.**
- 2) The current law provides no economic incentive to contracting because the provider is paid exactly the same whether in-network or out of network, thereby inducing the dismantling physician networks by both plans and providers; and
- 3) By granting all rate setting power to the payor, the current law leads to a devaluation and discounting of physician services reflected in both the contracted rates and non-contracted rates, creating an adverse practice environment for physicians in Connecticut.

To be clear, patients in Connecticut are protected from balance billing for out of network hospital based services under the Connecticut law. Our legislation does not diminish that protection.

Pathologists, like emergency physicians, are legally and ethically obligated to provide services to patients. We cannot and do not defer the performance of pathology based upon the insurance status of the patient. To consider the insurance status of a patient, in many cases would violate ethical and legal standards. Thus, there is no sound public policy logic to this differentiation in payment.

Why is the use of FAIR Health Inc. important for valuing physician services? Because the use of the FAIR health database is the most **objective and transparent way to determine “usual and customary” rates for physician services.** Our position is supported for reasons elucidated in a report made to the federal Health and Human Services Department (HHS) in 2014 by the University of Chicago (NORC). The report found:

“The mission of FAIR Health is to provide transparency to the health care and health insurance marketplaces. FAIR Health grew out of a lawsuit with United Healthcare and Aetna where plaintiffs claimed the insurers were misrepresenting usual and customary charges for services...Sixty insurers and employers donate medical claims to FAIR Health. FAIR Health has medical claims for approximately 150 million covered lives, 16 billion medical procedures and these figures are growing...For the immediate future, FAIR Health is the database best suited to help address CMS’ concerns about establishing comprehensive and transparent out of network payment benchmarks.”

It is for this very reason that the out-of-network New York law uses the Fair Health database for determining all out of network payment. There is simply no logical or sound public policy reason for Connecticut law to establish adverse payment differentiation between hospital-based medical specialties. Accordingly, we urge you to correct the inequitable and deleterious out-of-network payment formula currently established under Connecticut law. The correction of this error in law serves the interests of health care quality, physician access and patient care.

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