

October 20, 2017

Hon. Matthew E. Baker
213 Ryan Office Building
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Harrisburg, PA 17120-2068

Dear Representative Baker:

We thank you for the opportunity to comment on **House Bill 1553**. We are a coalition of medical specialties dedicated to preserving quality patient care and fair insurance coverage. Our coalition includes these organizations:

The Pennsylvania Association of Pathologists (PAP)
The Pennsylvania College of Emergency Physicians (PACEP)
The Pennsylvania Radiological Society (PRS)
The Pennsylvania Society of Anesthesiologists (PSA)
The Pennsylvania Society of Oncology and Hematology (PSOH)
The Robert H. Ivy Society of Plastic Surgeons (IVY)

We also have the support of the Pennsylvania Medical Society (PAMED).

We have a number of specific concerns with the current draft of this legislation. Those concerns can be summarized in seven general statements, each of which is discussed more fully later in this correspondence:

- 1) Insurers must be compelled to ensure that covered patients have adequate insurance networks and transparent insurance policies.
- 2) Physician waivers of out-of-network charges must be explicitly protected in the legislation.
- 3) “Usual and Customary Charges” must be defined to prevent health insurance companies from unilaterally imposing an arbitrary payment amount to out-of-network providers.
- 4) Arbitration is a time- and resource-consuming channel for challenging unilaterally imposed, arbitrary interim default payments submitted by insurers.
- 5) The Unfair Trade Practices Act, applied to physicians in this legislation, should rather apply to insurers engaging in deceptive trade practices.
- 6) The legislation is overly broad and should not include services provided in a physician office or clinic.
- 7) Any reasonable response to regulating out-of-network payments should be based on data defining the breadth and scope of surprise out-of-network billing in Pennsylvania.

We believe that resolving these issues is critically important -- or HB 1553 will not address what we consider to be the heart of the matter: that large insurance companies in Pennsylvania (and the nation) impede patients' access to fair health insurance coverage in the absence of adequate in-network services.

Each of our specific, enumerated concerns is discussed below, followed by some general observations:

1. Insurers must be compelled to ensure that covered patients have adequate insurance networks and transparent insurance policies.

Balance billing usually occurs as the result of inadequate health plan networks at hospitals and facilities. Accordingly, we believe **any proposed Pennsylvania law addressing out-of-network billing should include 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.**

With respect to this issue, current American Medical Association (AMA) Policy on Network Adequacy (H-285.908.11) states: *“Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including facility- and hospital-based physician specialties, (i.e., radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.”*

Therefore, to effectively promote comprehensive networks, this legislation should include provisions which would prohibit any health insurance plan from directing any communication to enrollees, or consumers who may be potential enrollees in a health plan, by any means, including through an on-line directory, written or web-based material, or in any advertisement, that implies, directly or indirectly, that a hospital is in the health plan's network when medical specialties that provide required services to those consumers as part of treatment in that hospital are not providers in the health plan network. This provision would usually, but not exclusively, include the specialties of: a) anesthesiology; b) emergency medicine; c) radiology; and d) pathology.

It is important in this context that a network should be assessed for adequacy based on the lowest cost-sharing tier; a network is not determined to be adequate when a substantial portion of the physicians are in the highest cost-sharing tier and essentially unaffordable to patients.

Transparency in out-of-network coverage is an essential first-step to help patients determine whether it is cost-effective for them to pay higher premiums to receive access to more physicians and if they will truly receive the coverage advertised. The health insurer should make public in a clear and conspicuous manner the factors it uses to build its provider network, including a description of the network and the criteria used to select and tier providers. Health plans should also be required to maintain and provide to their enrollees current and accurate provider directories.

2. Physician waivers of out-of-network charges must be explicitly protected in the legislation.

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According to a recent national survey published in The American Journal of Managed Care, approximately 22 percent of individuals who used out-of-network providers negotiated the terms of their bill with the insurer or provider, and 58 percent were successful in reducing their costs for at least one of the bills. For those patients seeking a change in the bill, **63 percent were successful in reducing their bill when conferring with the out-of-network provider.**

Nevertheless, some health insurance plans 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.

Out-of-network payment legislation should expressly allow physicians to waive out-of-network charges, including any balance-billed amount, coinsurance or co-payment billed by the physician based upon patient economic necessity and protect these physicians from any civil cause of action or requirement for approval by a health plan, or to any sanction or prosecution before any state court or oversight board.

Patient out-of-network costs should count toward their out-of-pocket maximum. Federal law created important stopgaps for out-of-pocket costs to patients as it established individual and family maximums.

However, at insurers' discretion, maximums usually do not include the out-of-pocket costs for out-of-network care, leaving the patient still vulnerable to significant, unanticipated health care expenses. Given the shift toward narrow networks that result in more frequent use of out-of-network providers, the requirements should allow patients to count these expenses toward their out-of-pocket maximums, or at least incent insurers to do so.

3. “Usual and Customary Charges” must be defined to prevent health insurance companies from unilaterally imposing an arbitrary payment amount to out-of-network providers.

The legislation provides ill-defined payment parameters to be used both by insurers in determining payments and by an Arbitrator, but does not define “usual and customary charges” as determined by an independent database of charges.

“Usual and Customary Charge” is NOT an arbitrary “fee schedule.” Rather, it is a broad geographic and market-based, data-driven usual charge. More specifically, the legislation should include in the parameters for out-of-network insurance payment and in the parameters for the Arbitrator's recognition: a usual, customary and reasonable rate meaning the 80th 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 **many of these plans already avail the 80th percentile of the FAIR Health Inc. charge database for calculating out-of-network payment.** Current use of this methodology by insurers reflects the suitability and appropriateness of this payment formula.

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 to govern out-of-network 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 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.). [Section 3241(b)(1)(A)].

The Commonwealth of Pennsylvania has already adopted FAIR Health standards in its workers compensation payment system. The Workers’ Compensation Act’s medical cost containment amendments, adopted in 1995, impose a cap on reimbursement to physicians and health care providers. The Bureau of Workers’ Compensation’s regulations provide extensive detail with respect to reimbursement rates.

Because the Department of Labor and Industry does not have access to a reference that would assist it in determining what constitutes the “usual and customary charge” for many services, it published a Notice in the *Pennsylvania Bulletin* and an interpretive guideline, which states as follows:

Effective November 1, 2010 when resolving applications for fee review under 34 Pa. Code §127.256, the Department will utilize the 85th percentile of the MDR database **published by FAIR Health** to determine the usual and customary charge as defined in 34 Pa. Code §127.3.

Given the independence of the FAIR Health MDR database, its adoption in multiple jurisdictions, and its adoption by the Pennsylvania Department of Labor and Industry, we strongly urge that an independent national or state-wide database such as the FAIR Health database should be adopted into Section 303(b)(1) as the initial, minimal default payment mechanism required to be paid by insurers to out-of-network providers, and as a major, if not the primary, standard for arbitration.

As currently worded, Section 303(b)(1) of HB 1553 states:

(b) Payment for health care services. -- If an insurer receives a surprise bill form and bill from an insured or if an out-of-network provider submits to an insurer a bill for a health care service covered by this Act:

(1) The insurer shall pay, in accordance with the prompt payment requirements under Section 2166 of the Act of May 17, 1921, known as the Insurance Company Law of 1921, **the out-of-network amount due under the health insurance policy or as required by federal law.**



Advocates indicated that this section was designed to prevent an insurance company from refusing to pay anything to an out-of-network provider and was not intended to create a limit on the amount of reimbursement available to a provider. Unfortunately, the actual words in the legislation do not achieve those goals. In fact, the opposite is true.

The phrase “out-of-network amount due under the health insurance policy” allows insurers to unilaterally determine the interim amount paid without any transparency to the out-of-network provider. Reimbursement to an out-of-network provider by definition means the out-of-network provider has no contractual relationship with the insurance company, has no way to find out the actual amounts payable under the insurance policy, and the insurance company has no legal obligation to provide any data or transparency. Insurers can then arbitrarily set these rates.

Several provisions of HB 1553, and especially this provision, significantly increase the market power of major insurers, to a level even higher than it already is. Four major insurance companies hold significant (and in a purely economic sense – monopsony) market power in many areas of the state. This market power presents a significant risk of increased costs and reduced access for consumers in Pennsylvania.

HB 1553, in an effort to reduce the effects of physician balance billing, may have the effect of transferring even more market power to the insurance industry in the Commonwealth, making it even less competitive and leading to reductions in access and increases in overall consumer cost. To achieve its real goals, HB 1553 must protect consumers from the increasing market power of insurers at the same time as it protects them from “surprise” out-of-network bills.

4. Arbitration is a time- and resource-consuming channel for challenging unilaterally imposed, arbitrary interim default payments submitted by insurers.

Arbitration as currently described by HB 1553 is much too costly and time consuming to use to determine payments for a large number of claims.

In HB 1553, after the insurance company makes the payment under §303(b)(1), the provider must accept assignment of benefits under §303(b)(2). Section 303(b)(3) states that “the insurer and provider may reach agreement as to an additional amount to be paid,” in addition to the cost-sharing amount owed by the insured to be paid in full.

As currently drafted, and as indicated in detail above, §303(b)(1) provides no incentive whatsoever for the insurer to make any reasonable payment. The insurer has no reason to negotiate a higher amount of reimbursement to the out-of-network physician because it can unilaterally determine the amount owed.

Section 303(b)(4) states that if the provider and insurer do not reach agreement on a payment amount, either through negotiation or otherwise, either party may submit the dispute for formal resolution under Section 304. As currently written, HB 1553 creates no reason for an insurance company to trigger arbitration. Only physicians and providers will initiate arbitration due to the potentially low amounts paid by insurers in the preceding sections.

Section 304(a)(2)(i) mandates the American Arbitration Association (“AAA”) to be the exclusive dispute resolution process. Under the AAA arbitration rules, the party initiating arbitration has to pay a

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filing fee based upon a range determined by the amount the party believes to be owed. AAA arbitration rules provide for full discovery (including requests for production of documents and depositions).

The process includes pretrial briefs, a full trial before at least one arbitrator appointed by AAA and post-hearing briefs. In addition, the parties have to pay the arbitrator's fees, which are often at least \$400 per hour. Simply stated, parties expend the same amount of money on legal fees for the entire pretrial, trial and post-trial process as they would in typical federal and state court litigation, *and they have to pay the judge as well*. There are no rights to appeal an incorrectly decided arbitration case. There are simply no cost savings to the parties in AAA arbitration.

To mitigate the burden of arbitration proceeding for all involved, provisions of the Bill should establish at least a minimum value of a claim below which arbitration would not apply. When the amount charged falls below this value, it should be paid in full, less deductible or co-insurance. The state of Texas, in Texas Senate Bill 507 which was signed into law on May 23, 2017, has established this type of “floor” limiting claims to be subject to its mediation process to those greater than \$500.

5. **The Unfair Trade Practices Act, applied to physicians in this legislation, should rather apply to insurers engaging in deceptive trade practices.**

The legislation applies the *Pennsylvania Unfair Trade Practice Act* to physicians who fail to refund monies even once to the insured. As a pattern, we agree that this is unacceptable behavior – as an isolated inadvertent incident, this is a harsh penalty.

If the Unfair Trade Practices Act is invoked in this legislation, it should also be applied to health insurance plans **that deceive and misrepresent** to enrollees and consumers that their health insurance products have in-network hospitals and in-network facilities when the plans have failed to contract with medical specialties that provide required services as part of treatment to patients in those hospitals.

6. **The legislation is overly broad and should not include services provided in a physician office or clinic.**

The proposed legislation includes in the definition of “facility” a “physician’s office or clinic.” This definition inordinately expands the purview of the law. **HB 1553 is meant to address out-of-network physician services at an in-network facility.** The issue of out-of-network billing exclusively focuses on the provision of out-of-network physician services at in-network facilities.

Other states have not found the need to address billing by community-based physicians. The referrals of in-network community based physicians are largely controlled and dictated by insurance carriers and no state, including Pennsylvania, has reported that referrals from these physicians are germane to the balance billing issue. The direction and control of referrals by the insurance plans applicable to community-based providers does not apply to the hospital setting, hence the problem of out-of-network billing from in-network hospitals and facilities.



7. Any reasonable response to regulating out-of-network payments should be based on data defining the breadth and scope of surprise out-of-network billing in Pennsylvania.

Billing a patient for out-of-network services is not new. The recent change is that the narrowing of insurer's provider networks -- and the increase in patient deductibles and co-payments -- increases the potential for patients to receive "surprise" bills in the form of higher cost sharing and out-of-network charges.

We have requested access to more detailed data available to the Pennsylvania Insurance Department regarding the magnitude of out-of-network billing in the Commonwealth. Last year, the Insurance Department publicly reported only 45 balance billing complaints out of approximately 75,000 health insurance complaints received between 2010 and 2015. **To help understand the scope and create the most appropriate legislation to address the concern, this information is vital.**

In the absence of more recent Pennsylvania data, we reviewed a report to the California legislature from the California Health Benefits Program in January 2016. In that state, before the passage of limits on balance billing, 0.63 percent of hospital admissions were associated with a "surprise" balance bill, and the average amount of that bill was \$550.

Based on California's experience, the percentage of "surprise" out-of-network bills actually submitted could be conservatively estimated as, at most, 2 to 3 percent of charges, with many of those bills resulting in only small patient payments.

Sections requiring clarification in House Bill 1553

The legislation expressly prohibits an out-of-network provider at an in-network facility from sending a "surprise bill" to a patient in excess of the in-network cost-sharing amount applicable to the patient. Other provisions of the bill address scenarios wherein patients receive a "surprise bill" that appear to be inconsistent with the provision that precludes such billing.

This legislation should, but does not, exclude out-of-network facility-based providers that furnished services when the patient had the opportunity to select an in-network provider, but failed to exercise the option. In those cases where a patient has the "control and ability to select an in-network provider," the patient should not be financially "disincentivized" from making 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 conspicuously identify for the out-of-network provider whether the plan is constituted under federal ERISA law and thereby federally exempt from the purview of the legislation.

Potential for unintended negative impact

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Pennsylvania Coalition on Out-of-Network Services

HB 1553 as written would have an anticipated unintended negative impact on the economy. It would eliminate options for physicians in the health care market in the Commonwealth, leading to even greater access issues for patients. Providers across Pennsylvania will feel the impact of this legislation on their bottom lines, forcing them to make tough decisions that may include closing their practice and leaving Pennsylvania.

Moreover, it would not only impact patients who may not have access to hospital-based care, but Pennsylvania’s economy as well. Physicians are a significant economic driver in Pennsylvania, creating \$53.0 billion in economic output, supporting 355,013 jobs and contributing \$2.2 billion in state and local tax revenues. One must consider the potential adverse economic effects on the Commonwealth of this proposed legislation.

We greatly appreciate the opportunity to comment on the legislation. In sum, we look forward to working with the Legislature in all efforts to protect patients from insurance industry practices that deny them the full continuum of in-network care or otherwise deceptively encourage them to purchase insurance products that do not meet basic standards for hospital-based physician network adequacy.

Respectfully submitted:

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Pennsylvania Coalition on Out-of-Network Services

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