COLLEGE of AMERICAN PATHOLOGISTS

June 5, 2019

The Honorable Lamar Alexander
Chairman
Committee on Health, Education,
Labor, and Pensions
U.S. Senate
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
Committee on Health, Education,
Labor, and Pensions
U.S. Senate
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

The College of American Pathologists (CAP) appreciates the opportunity to provide feedback on the Lower Health Care Costs Act of 2019, including specifically the section on surprise billing. The CAP has been constructively engaged on this issue for many years and we are committed to protecting patients and ensuring continued access to high-quality health care. It has always been our position that patients should not be financially penalized for the failure of health insurance plans to establish adequate in-network access to hospital-based physician specialties. Through no fault of their own, patients are caught off guard when an insurer does not cover certain physician services. Patients do not need additional financial stress when they are at their most vulnerable. However, we strongly oppose key pieces of the legislation you have proposed as those provisions contain an inequitable payment formula that would enrich health plans while undermining the economic viability of health care delivery, impede patient access to facility and hospital-based specialist physicians, and create a clear economic incentive for health plans to further narrow their physician networks.

The CAP believes that to protect patients from gaps in their health insurance coverage, insurers and providers should settle all payments without the patient's involvement, including the use of an independent arbitrator to settle disputes. Network adequacy standards for health plans should be set, and at a minimum, there should be network standards for ensuring that an appropriate number of specialty physicians are available to provide medically necessary services at "in-network" facilities. Additionally, it is critically important that out-of-network payment mechanisms not, in any way, deter, displace, or discourage equitable health plan contracting for physician services, as we believe such contracting is critical to maintaining the private commercial marketplace that consumers continue to support. Finally, any reimbursement for out of network services should be based on data compiled by independent, non-affiliated organizations, like FAIR Health Inc. or a state's all-payor claims database (APCD).

For these reasons, we urge you to consider several needed improvements to your draft legislation that would protect patients and preserve the non-governmental health care marketplace. Namely, in response to your legislative draft, the CAP emphasizes that we support fair reimbursement for out-of-network services, inclusion of an arbitration system that allows arbitrators to consider several factors to resolve payment disputes, and

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setting network adequacy standards that do not compel compliance while eviscerating the entire system of contracting.

CAP opposition to use of in-network payment rates

To encourage health plans to contract for physician services, and to ensure that the health care delivery system is financially viable, a fair market rate should be paid for physician services. Unfortunately, the HELP draft establishes a minimum payment standard set at the median contracted in-network rate. The CAP has consistently argued that caps on payment for physicians treating out-of-network patients should be avoided, but if pursued, guidelines or limits on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database (such as FAIR Health Inc. or a state's all-payor claims database (APCD)). We urge you to make this revision in your draft legislation.

It is important that guidelines or limits not be based on in-network rates because to do so would eliminate the need for insurers to negotiate contracts in good faith. Further, if in-network rates are used, insurers have an incentive to lower rates as low as they can and have the unilateral ability to do so. The CAP opposes the use of a rate that can be wholly controlled by one party. In the end, it is important to remember that it is doctors who care for patients, not insurance companies. Accordingly, any prohibition on out-of-network billing should be paired with a corresponding payment process that is keyed to the market value of physician services, or include some other kind of methodological safeguard.

Support for fair, transparent commercial benchmarking and arbitration process

The CAP has urged legislators to create a system whereby insurers and providers can come to agreement independent of the patient, who should only pay for care at an in-network rate. While the HELP committee draft includes an option for arbitration, this process is flawed from the start. To start, the CAP cannot support using the median in-network (or contracted) rate for any bill under $750. It leads to similar problems outlined above whereby one party is able to control all pricing under that amount. Pathology services very often fall under the $750 threshold. While this is good for having fewer high surprise bills, this will drive many labs out of business and/or lead to hospitals jettisoning labs because they are no longer profitable. Further, an independent dispute resolution (IDR) process must be able to consider several factors pertaining to the case. An arbitrator should be able to consider things like complexity and duration, but also other factors that either the insurer or provider may submit. Parameters that include geographically-based charges by providers and payments from insurers should be used to determine the fair market value of the physician service. It is imperative that a benchmarking rate based on in-network rates not be a primary factor in determining a starting point or an outcome for any arbitrator, as this would immediately bias the process and defeat the goal of IDR.

For example, the law enacted by New York State, which we believe is the optimal approach to protect patients from surprise medical billing, includes mediation/arbitration between insurers and providers. The payment methodology upon which the "usual and customary rate" (UCR) is calculated is based upon the 80th percentile of FAIR health database charges to reflect the market value of physician services. And it is clear this approach is working. Researchers at Georgetown University recently determined that "insurer, provider, and consumer stakeholders generally agree that the implementation of New York's Surprise Billing law went smoothly, was relatively fair to all parties, and is working as intended to protect consumers from a significant source of financial hardship."[1] The Georgetown study also notes that state officials have reported a dramatic decline in consumer complaints about balance billing and physicians are largely satisfied with the process and its results. Finally, concerns about inflated charges are thus far proven unfounded, as one study found a 13 percent average reduction in physician payments since the law was enacted in New York.

Opposition to network matching as solution to network adequacy shortcomings

The CAP strongly believes inadequate networks are the root cause of surprise bills. Unfortunately, the HELP draft does little to help address this issue. Where it attempts to address this issue, it forces physicians to be part of a network, giving them no power to enter into a contract willingly and no leverage to ensure fair practices.

This requirement would be difficult to operationalize, especially from a timing perspective. Hospital contracts with insurers can be multi-year, so there would too often be scenarios where the hospital has dropped or changed a contract with a particular insurer, yet the physician group contract with that same insurer would not yet have expired, or vice-versa. Further, a single insurer often has numerous products that each reflect a range of network breadths. To try and align each of these products across each hospital and any physician groups involved will introduce even further additional administrative complexities. In addition to this complexity, requiring physicians to contract with certain insurers as a condition of practicing at a particular hospital leaves physicians with little protection against abusive or exploitive business behavior by payers and hospitals. A more appropriate solution is network adequacy requirements.

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, and states are starting to take notice. In December of 2017, the Washington State insurance commissioner fined a health insurer $1.5 million and detailed steps it must take to fix its provider networks. Most recently, in Texas, the Center for Public Policy Priorities reported in 2014 that one health plan in the state had no pathologist providers at 20 percent of their in-network hospitals. Then, in October

[1] https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9

2018, this 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.

The CAP supports federal enactment of network adequacy requirements similar to the law of Louisiana (Network Adequacy Act 22§1019.1 et seq,) that expressly require 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 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. Most recently, the State of Washington also enacted this requirement. However, the vast majority of states do not currently have such hospital-based physician requirements and thus should be compelled under federal law to adopt appropriate network adequacy requirements.

A caution regarding price transparency

A lack of information about the cost of health care services can be an impediment to transparency and patient empowerment, but the CAP generally opposes adding additional administrative requirements on physicians that interfere with or impair the patient's medical diagnosis and care. Transparency alone cannot solve the surprise bill problem for patients, as many physician services are unexpected and cannot be anticipated by the patient.

Specifically, we wish to emphasize the unique difficulty that faces pathologists in providing patients with information about out-of-pocket costs in advance of services. For instance, a surgical or invasive diagnostic procedure performed by a dermatologist, surgeon, gastroenterologist, urologist, or other clinician may result in no specimens obtained or it may result in multiple specimens requiring anatomic evaluation. Additionally, anatomic pathology services typically involve a pathologist performing microscopic analysis of tissue or body fluids to determine whether cancer or other disease is present and, if so, its characteristics. The type of specimen or complexity of the analysis is often not known in advance of the initial microscopic analysis conducted by the pathologist, making it impossible to provide a reliable estimate of charges or costs. Providers should be transparent about their own anticipated charges at the time of scheduling, and insurers should be transparent about the amount of those charges they will cover. However, in going any further, the difficulty of price transparency poses administrative hurdles and significant risk for patient harm from any delays.

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Summary

As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide. As you move forward to address the issue of surprise billing, it is of paramount importance to strike a compromise that holds patients harmless but also allows providers and insurers to come to agreement on outstanding bills. We urge you to consider revisions that would better support fair reimbursement for out-of-network services, include an arbitration system to resolve payment disputes, and add appropriate hospital-based physician network adequacy standards that do not force providers into contracts.

Thank you for your consideration of this important issue and we look forward to working with you to come up with the best solution for ensuring patients have in-network access to physician services or are otherwise protected from out-of-network charges that result from health plan inadequacies. If you would like to meet, or have any questions, please contact Michael Hurlbut, Assistant Director, Legislation and Political Action, at mhurlbu@cap.org or 202-354-7112.

Sincerely,

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