Wisconsin Society of Pathologists

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December 15, 2017

Via email: elizabeth.hizmi@wisconsin.gov

Hon. Theodore K. Nickel
Wisconsin Office of the Commissioner of Insurance
125 South Webster Street
Madison, WI 53707-7873

Re: Comments on the Proposed Draft Network Adequacy and Balance Billing Legislation

Dear Commissioner Nickel:

The Wisconsin Society of Pathologists (WSP) appreciates the opportunity to offer comments on proposed draft legislation of the Office of the Wisconsin Insurance Commissioner (OIC), addressing health plan network adequacy and out-of-network balance billing.

OVERVIEW

The problem of balance billing emerges in scenarios wherein patients cannot access in-network providers at in-network hospital and facilities. In these situations, out-of-network physicians are under ethical and sometimes legal obligations to provide medical services for their out-of-network patients. These obligations are applicable to emergency medicine, radiology, pathology, and anesthesiology.

As noted, the out-of-network care is frequently the result of the *health plan's failure* to contract for such services that would otherwise be available to the patient. As you know, health plans have clearly endeavored to shrink and narrow their insurance networks, and thereby shift these costs on to their enrollees as out-of-network services. This deliberate and manipulative business practice can only be remedied by holding the health insurance payer financially and operationally accountable for these improper business practices. Accordingly, health plans in Wisconsin should not be financially incentivized by OIC to further shrink or narrow their network by establishing an out-of-network payment scheme that will enrich these health plans to the detriment of health care delivery.

The OIC proposal, in our view, confers financial incentives for participating provider (PPO) health plans that fail to build insurance network to ensure that their enrollees have reasonable and timely access to facility and hospital-based physician services. Moreover, in our view, the OIC network adequacy requirements, as proposed, fail to ensure that health plans in Wisconsin fulfill their obligations to contractually enlist physicians into their in-network

hospital and facility based sites of services. Accordingly, WSP strongly opposes the proposed bill unless amended.

I- The OIC Proposed Legislation Financially Favors Health Insurance Plans To the Detriment of Health Care Delivery By Embracing A Radical California-Style Solution To Physician Payment

We strongly oppose the out-of-network payment methodology set forth at 609.29 (3) (P.37 lines1-5) which proposes to codify a "Reasonable Payment Option" for an out-of-network provider as the "higher of the insurer's contracted rate for the same or similar service in the same geographic area or 125 percent of the Medicare program's reimbursement rate for the same or similar service."

In our opposition to this formula, the WSP fully supports the "Consensus Principles" advocated by the American College of Emergency Physicians (ACEP), the American College of Radiology (ACR), the American Society of Anesthesiology (ASA) and the College of American Pathologists (CAP), as follows:

> Medicare is not an appropriate benchmark for determining out of network payment. Medicare amounts are politically derived for the purpose of reimbursing medical services for a specific population based on federal budgetary and regulatory constraints. Such a methodology does not determine appropriate payment in other contexts, such as payment for commercially insured services. In addition, for some specialties, billing practices and amounts are not tied to Medicare.

Currently, of ten (10) states that ban balance billing (NY, NJ, AZ, MA, IL, MN, DE, CO, FL, CA) for out-of-network hospital and facility based providers, only one of these states California (CA) has opted to key out-of-network payment to Medicare. The California law on out-of-network payment keyed to Medicare has been in effect for less than six (6) months (2016 AB 72, effective July 1, 2017). The adverse impact of the California law on health care delivery is now nascent and not yet been objectively assessed. The concern is that the law has deleteriously undermined the ability of health care providers to negotiate market-based contracts with the health insurance payers.

It should also be noted that the California law is currently the subject of physician led litigation (*Association of American Physicians & Surgeons v. Brown, Gov. of California, et al.*, 16-cv-2441-MCE) to strike down the law. Plaintiff's pleadings note that "AB 72 gives insurers the incentive to decrease reimbursement rates to only 125 percent of Medicare."

The impact of using a Medicare fee schedule on out of network payment is likely to have a profound impact on in-network contracting to the detriment of health care delivery in Wisconsin. A recent report from the RAND Corporation concluded that for the State of New Jersey, an analogous payment rate for out of network payments set **between 90 percent and 200 percent of Medicare could reduce payments to hospitals by between 6 and 10 percent**. (See: "Evaluating the Impact to Regulate Involuntary Out-of-Network Charges on New Jersey Hospitals," RAND Corporation, November 2016) **We would expect a similar adverse impact on Wisconsin hospitals that cannot afford such cuts, especially in light of the uncertainty regarding the Affordable Care Act and the future of Medicare payment.**

In sum, the use of Medicare as a benchmark for out-of-network payment is highly skewed to benefit the insurance industry. Where legislation or regulation on this issue has been enacted, regardless of partisan composition, or ideological inclination, states and policy makers, for the most part, have recognized the need to maintain marketplace equilibrium between insurance payors and physician providers.

In December 2015, the non-partisan National Association of Insurance Commissioners (NAIC) in their 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 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."

For these reasons, even states as politically divergent as New York and Florida have keyed physician payment for out-of-network services to a market based charge formula that historically has been the basis for the "usual and customary" physician charge and health insurance plan payment. **Accordingly, we support use of the 80th percentile of FAIR Health Inc. charge database for determining "usual and customary" rates.**

In addition, payment should be made by health insurance plan directly to the provider. Some health insurance plans deliberately divert out-of-network payment to physicians, and instead provide such payments to enrollees. Out-of-network payment should always be made directly to the provider of the service, and not to the enrollee. The diversion of payment to the enrollee is a frequent business practice of health insurance plans to impede and encumber the collection of payment by the out-of-network physician, thereby driving up the administrative cost of care**. Accordingly, WSP proposes to amend 609.29 (3) (P.37 lines1-5) as follows:**

> **WSP Proposed Amendment**
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> A payment to a nonparticipating facility-based provider **shall be made directly** to such provider and is presumed to be reasonable if the payment is based on the lower of the provider's charge or the usual, customary and reasonable rate meaning the eightieth 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 insurance carrier. ~~higher of the insurer's contracted rate for the same or similar service in the same geographic area or 125 percent of the Medicare's program's reimbursement rate for the same or similar service in the same geographic area.~~

In support of the above proposed payment provision, Wisconsin OIC should note that on November 19, 2017 the National Conference of Insurance Legislators (NCOIL), in a bi-partisan vote endorsed model legislation that codified this formula for purposes of defining a "usual and customary rate" for determining out-of-network payment under their proposed model act entitled: "Out-of-Network Balance Billing Transparency Model Act." (See: http://ncoil.org/wp-content/uploads/2017/11/OON-Balance-Bill-Final-Model-1.pdf)

II. Proposed OIC Draft fails to Ensure Network Adequacy For Facility and Hospital-Based Physicians

With respect to network adequacy, WSP supports the current American Medical Association (AMA) Policy on Network Adequacy (H-285.908.11) that 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."

In addition, WSP supports the Network Adequacy policy of the Wisconsin Medical Society (WMS) (INS-058) that states that health insurance access plans assessed by the state should determine that: "Health plans have an adequate number of PCPs and specialists with admitting privileges at network hospitals" and that such plans should ensure: "availability of technological, diagnostic, and ancillary services."

The current OIC draft does not establish an explicit statutory mandate on the Insurance Commissioner to make a determination on approval of an access plan that includes consideration of a health plan's network adequacy for hospital and facility-based providers. This lax enforcement allows health insurance

plans to construct narrow networks that mislead enrollees into thinking that in-network facilities and hospitals provide reasonable access to in-network physicians in critical medical specialties.

The WSP agrees, in general, with 2016 comments submitted at the federal level by the Wisconsin Hospital Association (WHA), to the Centers for Medicare and Medicaid Services (CMS):

> WHA has consistently advocated for strong network adequacy to ensure that consumers have access to a selection of high quality providers in or near their communities, while not inhibiting care coordination and the growth of integrated care systems. As we have stated in previous comment letters, while strong network adequacy provisions are important, review of provider networks and enforcement of network adequacy standards are critical. Network adequacy requirements can ensure access to quality, affordable health care, but they are only as valuable as the enforcement and monitoring mechanisms behind them.[1]

In accordance with AMA and WMS policy, as cited above, **WSP proposes the following amendments to 609.23 Access plans (1) Page 23:**

> **New (m) The insurer shall annually submit a report for each network hospital that provides the percentage of physicians in each of the specialties of emergency medicine, anesthesiology, radiology and radiation oncology, pathology, and hospitalists practicing in the hospital who are in the insurer's network(s) so as to ensure enrollees with reasonable and timely access to these in-network physicians.**
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> **New (N) When determining the adequacy of a proposed provider network, the commissioner must consider whether the insurer's proposed access plan includes a sufficient number of contracted providers practicing at the same facilities with which the carrier has contracted for the proposed network to reasonably ensure enrollees have in-network access for covered benefits delivered at that in-network facility**

In addition, in accordance with WMS policy, WSP proposes to amend 609.20 (3) (d) as follows: (d) Technological, diagnostic, and specialty care services. This amendment helps to clarify the need to assess network adequacy for diagnostic services in the provision of high quality health care delivery.

III. ERISA Preemption Requires Health Insurance Payer Notification to Provider

As is well established under case law, state law governing out-of-network payment cannot be applied to federally constituted Employment Retirement Income Security Act "ERISA" plans. **Accordingly, WSP proposes to amend 609.29 (page 37) as follows**:

> **New (6) An insurer shall furnish an explanation of benefits to an out-of-network facility based and hospital-based provider within 30 days of receiving a bill from the insured or directly from the provider. The explanation of benefits shall conspicuously indicate whether the health plan coverage for the patient is subject to the requirements of this act, or otherwise preempted under 29 USC Section 1144(a)**

The notification as set forth above is necessary to ensure that health care providers are not **fraudulently misled** by health insurance payers regarding whether the out-of-network payment or mediation options are applicable to a plan that is categorically exempt under federal law by virtue of being an ERISA constituted plan.

IV. Mediation Provision Should Include "Usual and Customary" Criteria

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[1] Correspondence of Eric Borgerding, President, Wisconsin Hospital Association, to Andy Slavitt, Acting Administrator, CMS, October 6, 2016, Page 2.

WSP opposes the proposed mediation provision in the bill as too closely tied to the health insurance payer. WSP urges Wisconsin OIC to consider New York State law governing independent dispute resolution, which specifically includes criteria based the physician's charges and also based upon the market reflected in the UCR: (NY Fin Serv § 604). "Criteria for determining a reasonable fee. In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including: "(c) the physician's usual charge for comparable services with regard to patients in health care plans in which the physician is not participating" and "(f) the usual and customary cost of the service." Section 603 of the New York law defines "usual and customary cost" as follows:

> (i) "Usual and customary cost" means the eightieth percentile of all charges for the particular health care service performed by a 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 superintendent. The nonprofit organization shall not be affiliated with an insurer, a corporation subject to article forty-three of the insurance law, a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law, or a health maintenance organization certified pursuant to article forty-four of the public health law.

Accordingly, WSP proposes to delete the entire mediation provision and urges Wisconsin OIC to consider both the New York law, cited above, and the independent dispute resolution provision of the "Out-of-Network Balance Billing Transparency Model Act" that has been approved by NCOIL.

V. Clarification Needed to Ensure that Out-of-Network Providers Selected by Patients are Not Subject to the Payment Limitations and Requirement of the Legislation

As the NAIC made clear in its drafting notes to its 2015 network adequacy model act, the protection against balance billing for out of network services "is not intended to be used in situations where the covered person affirmatively chooses, prior to the provision of services, to obtain covered services from non-participating facility based provider. " Quite clearly, patients that select out-of-network providers have opted to be voluntarily held financially responsible for the higher payments associated with these services. **Accordingly, WSP proposes to amend Section 609.29 (Page 37 line 5) as follows:**

> **New (4) The requirement of this notice and payment limitation does not apply when the enrollee elects to receive an out-of-network provider service.**

We appreciate the consideration of these comments and our recommended amendments by the Office of the Insurance Commissioner.

Respectfully Submitted,

Wisconsin Society of Pathologists

cc: Mark Grapentine, JD, Senior Vice President, Wisconsin Medical Society
Kyle O'Brien, Senior Vice President, Government Relations, Wisconsin Hospital Association