



February 29, 2016

Honorable Teresa D. Miller
Commissioner
Pennsylvania Department of Insurance
Harrisburg, PA

Dear Commissioner Miller:

On behalf of the Pennsylvania Orthopaedic Society's (POS) 900 member surgeons, I thank you for the opportunity to comment on this important legislative proposal. The POS views "surprise" balance billing legislation as a necessary patient protection initiative. With that said, the POS believes that any solution should not sacrifice the interests of physicians solely to those of healthcare insurers.

Insurers do not provide healthcare services. Insurers do not treat ill patients or perform lifesaving/life improving surgery. Physicians do. Yet, physicians find ourselves in a reimbursement system in which insurers are allowed to set the value of the treatments we provide. It is our sincere hope that the Wolf Administration's surprise balance billing legislation **will not** continue this paradigm.

Our Society knows that the Department is aware of examples of surprise balance billing. The following is a variant of the typical out-of-network provider scenario. This example does not lead to surprise balance billing, but it may result in major inconvenience to patients and possibly adverse care outcomes. Unfortunately, this is an all too true example of how limited insurer networks affect patient care.

An auto accident results in a multiply-injured patient brought to the closest hospital where emergent treatment is given by various subspecialty providers. The patient will require multiple procedures after emergent stabilization. Some providers who will perform post-stabilization care, including orthopaedic care and anesthesia, are not in the insurer's network. Negotiations ensue among the affected providers and the insurer to reach a compromise on a payment stream for services due to the patient's need for multiple surgeries and other treatment. The insurer, however, refuses to allow the out-of-network providers receive any reimbursement for the proposed necessary medical treatment. As a result, the patient is transferred to an in-network facility 90 minutes away to be treated by in-network providers at an in-network facility.

While this example did not result in surprise balance billing, it illustrates how limited insurer networks dictate patient care. It is an all too common scenario in which we find ourselves.

In this letter, the POS will give general comments on the proposed legislation. Our Society is happy to work with the Department on specific legislative language at your convenience.

At our February Board of Directors meeting, the POS leadership determined that any surprise balance billing legislation should conform to four basic principles. They are:

- 1) First and foremost, this issue is about patient access to quality care. Shrinking insurer provider networks and expanding hospital contracting practices, however, leave certain specialty physicians without a clear reimbursement path for their services. This, in turn, may lead to physicians seeking payment directly from patients. Insurer payment practices must ultimately ensure patient access to quality care.
- 2) The solution should not adversely affect physicians who are merely seeking to be compensated for the lifesaving/life improving services we provide to our patients.
- 3) The solution should allow physicians to have equal footing with healthcare insurers in a dispute resolution process.
- 4) The solution should not lead to the end of physician private practice.

Surprise balance billing can be the direct result of healthcare insurers intentionally limiting their provider networks to maximize their profits. By excluding certain high risk specialists from their networks, healthcare insurers shift the burden of high cost, but lifesaving/life improving treatments, procedures or surgeries to patients. To remedy this growing trend, the Wolf Administration should consider requiring healthcare insurers to have full and adequate provider networks and, further, the Administration should enforce these requirements. In addition, breaking up the effective regional monopolies enjoyed by some of Pennsylvania's healthcare insurers would create more competition among insurers in portions of the Commonwealth, and thereby, expand provider networks. These are bold and controversial reforms, but they are necessary if Pennsylvania's patients and physicians are to find a measure of balance in our healthcare delivery system.

Currently, out-of-network physicians who provide lifesaving/life improving treatments or surgeries to patients, particularly in a hospital setting, must seek reimbursement directly from patients. This is the result of healthcare insurers' refusal to negotiate provider contracts with hospitals and physicians and has forced hospitals to seek contractual relationships with certain specialty physicians to maintain their array of services and licensure and accreditation status. This system is unsustainable and adversely affects both patients and physicians.

"Any Willing Provider" legislation is a good first step in resolving shrinking insurer networks and the surprise balance billing issue, but is not a total solution. Simply enacting any willing provider legislation further reduces healthcare insurers' need and desire to negotiate provider contracts and may lead to the further reduction of private practice physicians. The ultimate remedy lies in a combination of any willing provider and a modification of the dispute resolution process envisioned in the Department's proposed legislation.

The POS recommends that the Department consider legislation that provides a two-step process. First, when out-of-network physicians provide healthcare services at in-network facilities, those physicians

should initially receive in-network reimbursement for the services provided. Second, if out-of-network physicians believe they should receive more than in-network reimbursement, they can enter a dispute resolution process in which insurers must demonstrate the additional reimbursement is unwarranted.

As we read the Department's proposal, out-of-network providers would receive **no compensation** for the care they render to their patients until the end of a dispute resolution process in which they must prove they deserve reimbursement. This scheme stacks the deck against physicians who provide lifesaving/life improving services to patients and in favor of healthcare insurers who simply take money out of the system. As currently written, the POS cannot support the Department's proposal.

Too often physicians find themselves in reimbursement regulatory schemes in which they have little leverage and must simply accept insurer payments regardless of whether those payments fully and adequately compensate physicians for the lifesaving/life improving services they provide. This surprise balance billing initiative heads down the same path of requiring physicians to treat patients, but then fight in a disadvantaged position, to receive just compensation for their efforts. Any legislation to assist patients should not continue the current paradigm in which physicians serve the needs of patients, but are at the mercy of insurers for compensation. This legislation should create a structure in which physicians at least receive in-network reimbursement following the delivery of healthcare services, then enter a dispute resolution process in which insurers must prove why physicians should not receive full value for their work.

Thank you for the opportunity to comment on this important legislation. The POS welcomes the opportunity to further discuss this issue with the Department.

Sincerely,



Samir Mehta, MD
President