Pennsylvania
MEDICAL SOCIETY®

February 29, 2016

Honorable Teresa D. Miller, Commissioner
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120

Dear Commissioner Miller:

Thank you for the opportunity to comment on the Pennsylvania Insurance Department's (PID) proposal to protect consumers from "surprise" balance bills. The Pennsylvania Medical Society (PAMED) shares your concerns on access to care issues and patient costs in health care including out-of-pocket costs that are often unanticipated by the patient. The PAMED Board of Trustees has spent considerable time discussing this very complex issue. In addition to our preliminary comments contained in this letter, we have created a physician Task Force comprised of physicians and in particular physicians who may be most impacted by the proposal including representatives from anesthesia, pathology, radiology, and emergency medicine. Our Task Force looks forward to working with the PID in the coming months to craft a solution that is reasonable for consumers and physicians alike.

Out-of-Network (OON) balance billing issues cannot be resolved in a vacuum. Other important and interconnected issues must be addressed in conjunction with or even before balance billing is addressed. "Surprise" balance billing is an inevitable side-effect of inadequate networks and unfair contracting and potential patient misunderstanding about the insurance products they have purchased. A network that does not provide adequate access to in-network care at contracted hospitals should simply not be sold to consumers. This lack of alignment in networks may be the primary root cause of many OON balance billing issues and needs to be addressed by the PID.

A recent study to measure the size of provider networks in plans sold on the health insurance marketplaces conducted by the Leonard Davis Institute of Health Economics at the University of Pennsylvania[1] found that it is difficult for consumers to assess network size, even as a broad concept. The study states: "[A]s a result, the trade-off between network size and premiums is not at all transparent. It is even hard to gauge which providers are in the network as this typically would involve checking the provider directories at the insurer's website for a particular provider for a particular plan. These provider directories are notoriously out-of-date." The study also found that it was also difficult for regulators to judge the adequacy of networks.

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[1] Polsky, D. and Weiner, J., *State Variation in Narrow Networks on the ACA Marketplaces*, Leonard Davis Institute of Health Economics, August 2015.

In addition, the study also looked at network size by state. Researchers found the following in Pennsylvania:

- 27% of the marketplace networks were small or extra small
- Of this 27%, 20% are PPO networks and 40% are HMO networks
- Ranks 25th among states for the percent of narrow networks in that state

Clearly, this has the potential to affect OON balance billing. The study referenced above concludes that HMOs have about twice the rate of narrow networks as other plan types. Pennsylvania has approximately a 29% HMO market penetration rate according to Kaiser State Health Facts, so the narrow network effect on OON balance billing could be significant in Pennsylvania and requires further study by the PID and education with consumers about the products and networks they are purchasing when they buy health insurance.

PATIENT PROTECTIONS

Network Adequacy

The first line of defense against OON billing should be a regulatory framework that fosters adequate networks that provide patients with timely access and choice. Critical to this are strong, measureable network adequacy standards that include evaluation of a patient's ability to access participating providers at participating hospitals. We would urge that attention be paid and specific adequacy measurements be applied, to hospital-based physicians and networks' ability to provide in-network access to the care patients need.

As a member of the National Association of Insurance Commissioners (NAIC) Network Adequacy Model Review (B) Subgroup, you received a copy of an October 26, 2015 American Medical Association comment letter which PAMED was a co-signer that commented on the Health Benefit Plan Network Access and Adequacy Model Act. In that letter, we stated that the model act needed stronger consumer protections in regards to network adequacy. These include:

- **Active approval of networks prior to products going to market**—The NAIC Model Act allows Insurance Commissioners discretion in approving health plan networks after they have gone to market. We believe this is fundamentally wrong. We would strongly recommend that all health insurance plans receive prior approval by state regulators of their networks before going to market. Additionally, if there are any material changes to access plans to an existing network that these also be prior approved before implementation.

- **The use of quantitative measures to determine network adequacy**—The Model Act outlines several types of quantitative measurements that may be used by regulators to determine network adequacy. We believe these quantitative standards should not be an option, but rather a requirement to assure network adequacy. Without clear quantitative metrics, regulators will find it harder to enforce their interpretation of sufficiency and consumers will be hard pressed to prove a given network is adequate in meeting their needs for covered benefits. These measures should include the following:
    - Full-time equivalent provider-covered ratios by specialty, including facility-based professionals;
    - Full-time equivalent primary care professional-covered person ratios;
    - Geographic accessibility of providers, including primary care professionals, specialists, hospitals and facility-based professionals;
    - Geographic variation and population dispersion;

- Waiting times for an appointment with participating providers, and in particular primary care providers;
- Hours of operation;
- The ability of the network to meet the needs of covered persons, which may include low income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency;
- The volume of technologically and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services;
- Limits on travel distance and travel time to providers in both rural and urban areas.

Other criteria could include the extent to which providers are accepting new patients, the degree to which participating physicians are authorized to admit patients to participating hospitals and hospital-based providers are participating providers, and the regionalization of specialty care, which may require some children and adults to cross state lines for care.

- **Regulation of tiered networks to prevent discriminatory network design**—The PID proposal has asked for comments on the effects of OON balance billing and tiered networks. Tiered networks are being designed in a discriminatory fashion and therefore hindering access to covered services. Many insurers simply use arbitrary cost figures that determine which tier level the physician is placed without regard to quality of care provided. In our joint letter of comment to the NAIC we discuss that "providers that may subspecialize and care for patients with more complex needs may be placed into higher cost-sharing tiers, forcing patients who need to access these providers to pay significantly more out-of-pocket even though such care is a covered benefit. In addition, the lowest cost-sharing tier may not include sufficient numbers or types of providers to offer consumers access to affordable covered services." Economic credentialing should not be used to determine which tier a provider is placed. Selection and tiering criteria must include a quality component that carries equal or greater weight than other components of the selection and tiering criteria. Lastly, all network adequacy standards must be applied to the lowest cost-sharing tier of any tiered network.

  We also believe that it is vitally important for insurers to be transparent regarding the criteria they use for selecting and tiering providers. They should be required to make their selecting and tiering criteria available for review and approval by state regulators. Providers should also be privy to this information. Full transparency of provider selection standards is critical, given the shift toward narrow and tiered networks, many of which seem to be designed on the basis of cost, rather than quality. Regulators should also be cautious in permitting insurers to label their networks as "high-value" or "high-performing," as this implies provider quality has been considered in the development of the network.

Transparency, Disclosure and Education

Transparency in OON coverage is an essential first-step in helping our patients better understand what OON benefits they have in a simpler way then they receive the information today. Consumers in all plans, no matter how narrow, deserve to be confident they will have access to a provider network that can deliver the benefits promised under their policy. Transparency is important between consumer and insurer, between insurer and practitioner, as well as the practitioner and their patients. According to a report issued by the Georgetown University Health Policy Institute's Center on Health Insurance Reforms and the Urban Institute[2] consumers should have:

- The ability to make an informed choice—an ability that is inadequate in the individual insurance market today—both inside and outside the marketplace. At a minimum, consumers need standardized information about the breadth and restrictiveness of plan networks, before they make a purchasing decision.
- The wherewithal too quickly assess what kind of network a plan has and compare it easily to other plans in their price range.
- Confidence that the provider directory is accurate and up-to-date. Insurers have an obligation to keep them current and avoid errors.
- Understandable information about each health plan's performance on enrollees' ability to obtain needed care quickly and easily, such as through a star rating system and consumer satisfaction scores.
- Data regarding policyholder use of out-of-network services, consumer satisfaction, complaints filed with the regulatory agencies, and internal and external appeals.

At the most basic level patients need to understand their financial responsibility for seeing non-participating providers. Insurers should disclose to patients at the time of enrollment and in subsequent patient communications (e.g., websites, patient portals) a range of out-of-pocket costs experienced by enrollees who obtained care from a non-participating provider. Further, insurers should be required to standardize the way in which they market and describe their out-of-network coverage, with comparisons to a realistic baseline derived from independent, out-of-network charge data. We also recognize the need for practitioners to volunteer fee information to patients wherever possible in advance of services being rendered.

It is also important that insurers base their payments to non-participating providers on usual, customary, and reasonable charges using charge data from an independent source. Transparency regarding how payment to non-network providers is calculated could minimize the unanticipated bills to patients for out-of-network care. As we have discussed with the Pennsylvania Department of Health, an All Payer (and other sources) Claims Database would be able to fill this role.

There also exists a need for transparency in network and benefit designs. As we alluded to in our discussion of network adequacy, restrictive network designs are replacing more robust networks, providing patients with lower-premium options on and off the Pennsylvania marketplace.

However, unanticipated costs often result when patients access care that is outside of the network or beyond the coverage offered by their plan. Similarly, a patient can face additional out-of-

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[2] Corlette S., Volk, J.,Berenson, R., and Feder, J., *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care*, The Center on Health Insurance Reforms, Georgetown University Health Policy Institute and the Urban Institute, May 2014.

pocket costs when a benefit is more restrictive than anticipated. For example, a lack of transparency in formulary designs can result in patients having to cover the costs of medications they believed to have been on their plan's formulary.

ADDITIONAL PATIENT POTECTIONS

There are two steps we believe the PID could immediately implement to address consumer concerns on out-of-network billing. First, as a mechanism to encourage participation, insurers issue payments directly to its participating providers on behalf of the patients who receive covered services. Many insurance carriers, including the Pennsylvania Blue plans do not extend this same courtesy to non-participating practitioners. Rather than pay the non-participating practitioner directly, some insurers issue payment for services rendered by the practitioner directly to the patient. To the surprise of many practitioners who have provided out-of-network services, the assignment of benefits is not likely to be honored by the insurer even after the patient has assigned their benefit to the practitioner.

Unbeknownst to the physician, a patient's subscriber agreement with the insurer may contain anti-assignment language. An anti-assignment clause will generally render the patient's assignment of benefits to the practitioner null and void. This clause gives the insurer the discretionary right to not accept the patient's assignment of benefits wishes. In many instances, the patient and the practitioner alike are unaware that the insurer's payments of the benefit will be sent to the patient. And, as many practitioners have discovered, it is not always easy to get insurance payments from patients who have cashed, and probably spent the insurance reimbursement check. Chasing patients for payment consumes valuable practice resources. Insurers figure paying patients directly may provide an impetus for non-participating practitioners to enter into participation agreements.

A number of states have enacted measures which require insurers to send payments directly to out-of-network providers. We believe that there are benefits beyond making it easier for the practitioner to receive payments. It could potentially lead to a decrease in the wrangling between out-of-network providers and insurers. It could also lessen the administrative burdens associated with managing out-of-network claims on both sides. It may even lead to the out-of-network provider accepting the in-network rate as payment in full. This may potentially help both patients and their provider particularly in emergency or surprise billing situations.

Pennsylvania's Quality Health Care Accountability Act (Act 68) obligates all managed care organizations to pay "all reasonable necessary costs associated with emergency services provided during the period of the emergency." 40 Pa. C.S. Section 991.2116 arguably supports recovery of actual "billed" charges. The term "costs" as used in Section 2116 appears to refer to "costs to patients," not costs incurred by providers. The standard applies equally to emergency services provided by facilities and medical professionals; even though there are no cost reports or determinations of reasonable costs for the latter. Regulations implementing Section 2116 likewise indicate that the measure of payment for emergency services is "reasonably necessary costs for enrollees meeting the prudent layperson definition of emergency services." 31 Pa. Code, Section 154.14(b), states without insurance, such "costs" to patients generally would be non-contracted providers' full billed charges. We therefore, would request that in emergency and surprise billing situations, practitioners are paid charges or a UCR rate derived from an independent source and that payments be made directly to the out-of-network provider.

Second, the Affordable Care Act (ACA), created important stop gaps for patient out-of-pocket costs, establishing individual and family maximums. However, at the insurer's 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. We would urge that regulators revise the requirements to allow patients to count these expenses toward their out-of-pocket maximums, or at a minimum, incent insurers to do so.

The Pennsylvania Medical Society looks forward to working with the Pennsylvania Insurance Department, the Pennsylvania Legislature, patients, and other stakeholders in developing appropriate consumer and physician protections for out-of-network balance billing. PAMED's leadership has spent considerable time discussing this complex and at times contentious issue. As we stated earlier, we have created a Board Task Force to thoroughly review this issue and make recommendations. We invite the PID to suggest a physician from your agency or partner agency who could serve on the Task Force representing the Wolf Administration in these deliberations as an ex-officio member.

Sincerely,

Scott E. Shapiro, MD, FACC, FCPP
President

cc: David Talenti, MD, Chair, Board of Trustees
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