

Pennsylvania Insurance Department Hearing
October 1, 2015
Comments from
America's Health Insurance Plans

Thank you for the opportunity to be part of this discussion to provide some additional information on scenarios consumers and insurers are facing, and the actions being taken in the states. My name is Candy Gallaher and I am here from America's Health Insurance Plans, a national association for health insurers offering coverage directly to individuals and groups, and through state programs like Medicaid and CHIP, and federal programs like Medicare Advantage. AHIP's members cover more than 200 million people throughout our nation.

We've been invited to speak today on behalf of our member plans in Pennsylvania, which include most, if not all, of the insurers offering health insurance here in the Commonwealth. We're here because the issues addressed in today's hearing are increasingly becoming issues in other places across the nation, and are of importance to all of us.

We'll start by outlining some key considerations:

- Health insurers contract with facilities, physicians and other professional providers to assure consumers have access to coverage for more affordable health services, access to a wide range of providers and clinicians, and protection from the unknown costs of balance-billing.
- Hospitals as inpatient or outpatient facilities provide services to consumers, and consumers going to hospitals that participate in their health plans' networks expect the services provided during those stays or visits to be part of that participating providers services.
- Some hospital-based physicians are employees of the hospital, and some are not. Some may be independent contractors that work *at* the hospital, but not *for* the hospital. In fact, as that trend increases, both hospitals and insurers are finding some hospital-based physicians choosing to remain out of insurance networks.
- This is a key concern with core services provided during a hospital stay or visit, when hospital-based providers such as radiologists - for reading diagnostic X-rays, cat-scans, etc., pathologists – for interpreting with laboratory results, and anesthesiology services performed by hospital-based physicians, or even emergency rooms physicians, choose not to participate in insurer networks. These represent most of the surprise billing cases

seen nationwide. Indeed, the costs of balance-billing by out-of-network providers can be unpredictable and sometimes extreme.

- AHIP today released a report – *Charges Billed by out-of-network Providers: Implications for Affordability* – that reviewed billed charges for 100 procedures using a national data base of charges, FAIR Health Inc.’s National Private Insurance Claims database. The report examined average out-of network billed charges and overall distribution of these data. I’ll cite just two procedures for you to think about: In Pennsylvania average charges for tissue examinations by a pathologist were more than twice as much as the Medicare fee schedule allowance, actually 280% more. And high intensity emergency room visit charges over four times as much, 407% more. Compared to the national numbers, the Pennsylvania charges are somewhat lower (the national averages for those two examples were 314% and 551% respectively), consistent with the other statistics in Pennsylvania, which reflect that Pennsylvania has more affordable premiums than nearby states.
- Consumers depend on insurers to work with providers to offer coverage options and protection from unexpected costs. The results of our out-of-network study underscore the importance of the need for consumer protections, and a consumer disclosure, if there are out-of-networks providers operating at a network facility.
- Consumers and employer groups benefit if hospitals and other facilities engage in good-faith efforts to ensure their hospital-based providers contract with the same networks that the hospital contracts with. This reduces, and can even prevent, the problem of surprise balance bills sent to consumers after discharge.
- Insurers depend on providers and other stakeholders to help protect consumers in these situations, and share the common interest of making coverage available and affordable to consumers. This is a multi-faceted problem that requires the engagement and commitment of multiple stakeholders to resolve it.
- Any solution that would require insurers to pay charges would be ill-conceived, and harmful to the overall health system, to hospitals, to consumers when premiums go up, and would provide the wrong incentive to those providers to not negotiate on charges, or contract with hospitals or insurers.

The out-of-network balance billing issues and costs facing patients, health plans and health care providers in Pennsylvania are not unique, and require thoughtful and balanced solutions.

Approaches to Resolving the Issue:

We believe in a balanced approach that accomplishes three goals: (1) protect patients from bills they are not responsible for paying; (2) provide for fair and reasonable payment to a non-contracted providers; and (3) provide for a dispute process when providers feel they have not been accurately or adequately paid.

Towards that end, we believe the following approaches would help resolve the issue:

- State approaches to out-of-network balance billing issues should focus on hospital-based non-contracting providers.
- Out-of-network hospital-based providers' contract status should be disclosed to consumers. Providing more disclosure and education to the patient when they plan to utilize a facility will assist them in making decisions.
- States should consider options to protect the consumers in those cases. There are several approaches to consider.
 - One is through statute or regulation to provide options to those out-of-network providers – to either accept assignment of benefits from that consumer for those services and agree not to balance bill the patient for any amounts beyond co-payments of co-insurance, or – to not accept assignment of benefits and bill the patient charges consistent with a charge amount aligned with a benchmark payment amount set by the state.
 - Another is a required notice that must be provided - and signature received - prior to performing those out-of network services, which if not performed would not permit that provider to collect any balance billing amounts.
 - Another is a review of patterns of balance billing or charges beyond copayments, coinsurance or deductibles when consumer protections have been enacted, and then determine whether there are excessive or unfair billing patterns that could prompt action by a state agency with jurisdiction.
 - States could also consider establishing a binding independent dispute resolution process for providers and insurers to resolve disagreements in these cases, which would take the consumer out of the middle.

Other States' Experiences:

There are various models that are being tried around the nation to address out-of-network services and payment:

- Illinois and Florida have both tried to institute provider dispute processes, but with limited and varied success.
- New York recently passed a law that went into effect in April this year that requires a provider dispute process through binding arbitration for certain "surprise" bills.
- Texas has a process for the consumer to seek a mediated review of "surprise" balance billing that recently moved the trigger threshold to \$500. It was previously \$1,000 and not frequently utilized at that level.
- New Jersey previously had a requirement to have insurers pay charges in these scenarios, but is currently working on legislation to address that unsustainable approach. We also note that New Jersey's health insurance premiums are much higher than those in Pennsylvania, in part due to that problem.

Together, these models reflect attempts that are occurring nationwide to resolve issues similar to those faced by consumers in Pennsylvania. This indicates that this issue is growing and attracting regulatory and legislative attention.

Discussions at the NAIC have also focused on this issue:

Recent discussions on an NAIC model on network adequacy have also proposed an approach to address this issue. It can be found in newly proposed language appearing in the most recent draft Model Act under "Section 7 - Requirements for Participating Facility Providers with Out-of-Network Facility-Based Providers", which includes:

- A notice provision required of both the participating facility, and out-of-network providers working at that facility to disclose that health professionals involved in the care delivered at the facility may be performed by non-contracted providers;
- A requirement that if an out-of-network facility-based provider bills a patient that provider must notify the patient of their right to:
 - co-pays and cost-sharing as if in-network,

- choose to pay the balance billing, or
 - (if the amount is over \$500) send the bill to their health care plan for processing using the benchmarked payment process, or
 - request a provider mediation process, or
 - exercise their right to appeals available in the state;
- A limitation on balance billing the patient in the above scenarios;
 - A process where the states establish a benchmark for insurer payments;
 - A provider mediation process that is established in accordance with one of the national mediation standards, and;
 - An enforcement provision.

It is new language that consumer groups, insurers, and regulators have supported. And we note the American Hospital Association (AHA) supported the new language in a comment letter dated September 22, 2015 " *The AHA supports the proposed revisions, which would create a balanced solution amongst providers, health plans and hospitals to better protect the consumer from unexpected bills.*"¹ We agree.

Closing

As you continue these important discussions, it will be critical to identify what the key problem is in Pennsylvania, how widespread it is, and to develop solutions to prevent and handle it so consumers are not put in the middle of a payment dispute. As noted previously, any solutions will have to carefully provide protection for consumers without creating increased care costs, disincentives for providers to participate in networks, unreasonable paperwork for providers and insurers, or one-sided solutions.

Thank you for considering our comments today. I'm happy to answer any questions you may have.

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http://www.naic.org/documents/committees_b_rftf_namr_sq_related_aha_cover_letter_and_suggested_model_revisions_09_22_15.pdf