

Testimony - Pennsylvania Insurance Commission Hearing
"Surprise Balance Billing of Health Insurance Consumers" - October 1, 2015

We are submitting this testimony on behalf of the Pennsylvania Society of Anesthesiologists and its more than 2,000 physician members from across Pennsylvania, in response to the September 8 announcement of a hearing on "Surprise Balance Billing of Health Insurance Consumers" made by Insurance Commissioner Teresa Miller.

First we want to thank the Insurance Commissioner and the Pennsylvania Insurance Department for raising the issue of "surprise balance billing" While the focus is on the surprise to patients, physicians too are often surprised when they find out that a patient's insurance does not cover a medically necessary service. In recent years, more stringent coverage limitations imposed by HMOs and PPOs are making this a difficult issue for many patients and physicians alike.

To the best of our knowledge, this is an informational hearing. It has not been called to provide comments on any specific legislation or regulation, but rather to shed light on the more general issue of "surprise balance billing" with the primary emphasis on the "surprise" which occurs when patients expect a medical service to be covered by their insurance policy and it is not.

What is described as "surprise balance billing" arises primarily because patients/insureds are unaware of limitations on their coverage, particularly as it relates to care provided by physicians who are not part of an insurer's network. In-network providers contractually agree with an insurer to accept specified rates for specified procedures. The agreed-upon payment is commonly at a discount from a provider's usual and customary rate. In return, however, subject to co-payments or deductibles, the insurer pays the provider directly, at the agreed-upon rate. The insurer also customarily notifies the patient of this payment and the patient's obligation for copayments and deductibles. Unfortunately, insurers often neglect to disclose non-coverage for medically necessary services provided in good faith to patients by out of network physicians. This is usually the root cause of surprise balance billing.

Out of network providers have entered into no agreement to discount their rates and to accept the insurer's payment, as supplemented by copays and deductibles, as full payment. A physician, or physician group, may be out-of-network for many reasons, ranging from "they weren't asked" to the insurer's determination that an adequate number of specialist physicians are already in the insurer's network to a disagreement over the fairness of payment levels. In these scenarios, it is unfair to expect the medical provider to accept payment at a rate the provider did not agree to. There is no legal basis to require the provider to do so. Insurers, in turn, seek to incentivize their insured's use of in-network providers by providing reduced coverage for services provided by out-of-network providers. As the Insurance Commissioner noted in the announcement of this hearing, insurers sometimes pay providers who are not in-network "only a small amount, if any, of the out-of-network provider's charges," leaving patients with significant financial hardship and both physicians and patients with collection

procedures both would like to avoid. Again, there are several reasons in play, including trying to influence out-of-network providers to become network providers.

So long as the health insurance system is built around physician networks, insureds who utilize non-network physicians will face greater balance billing than when they utilize a network provider. Minimally, what we should strive to do is to eliminate the “surprise”. For planned procedures, cost may be a significant factor in the health care decisions patients make, as well as which providers and even which insurers they choose. So it is very important that they have complete and accurate estimates of total costs in time to make informed decisions before services are performed.

One issue that can lead to surprise is that an insurer may have entered into an agreement with a hospital but not with those specialists, like anesthesiologists, whose care will inevitably be needed by many of the hospital’s patients. In that instance, an insurer’s representation that its network includes a particular hospital may be literally true but it is meaningfully false and readily misunderstood by prospective patients. That is particularly a concern when a particular specialty service is provided by a practice group that has an exclusive contract to provide those services and is thus “all in” or “all out” of network. Typically, nothing in an insurer’s website or other information will disclose that type of information, which is not apparent from a listing of who is in the network and what specialty services they provide.

We agree that health care providers generally need to be transparent to patients regarding their charges and the insurance plans in which they participate, and that physicians should offer to discuss expected charges and payment options with patients before services are provided, so that no charges for planned procedures would be a surprise. But anesthesiologists, although they provide a service vital to a patient’s successful outcome, have a different relationship with patients than do many other specialties and that difference makes early discussion of financial obligations difficult. Anesthesiologists commonly have their first contact with their patients on the day of surgery. That allows a meaningful discussion with patients about the anesthesia services to be provided, but not about costs, charges, networks, and the like. A patient can be told about network status, but there is little to be done if a patient is dissatisfied with the information, short of cancelling scheduled surgery. Of course, advance notice or any kind of meaningful discussions are impractical in emergency situations.

“Surprise balance billing” for out of network services is a multi-factorial problem, and any responsible solution needs to consider a variety of factors. These include

- The opportunity for patients, prior to receiving non-emergency treatment by any physician or health care facility, to be fully informed of the participation status and costs of all involved health care providers by means of, at a minimum, current participation lists maintained by their insurer, including information about specialists, linking them to a network hospital and showing, for each participating hospital, the specialists who have privileges there

- For a service requiring pre-certification, a comprehensive cost estimate provided by the insurer for a patient's specific service, before the service is performed, including anticipated costs to the patient of out-of-network providers.
- Information provided by health care facilities to enable patients to contact their out-of-network physicians to receive from them a description of costs that may not be covered by their insurance.
- Health care facilities and referring physicians, including anesthesiology practices, should maintain public online databases of their participation status and contact information of providers with whom they work and from whom their patients are likely to receive care.
- A requirement for insurers to provide adequate in-network provider options, including a full range of specialty physicians, as alternatives to out-of-network providers.
- The ability and willingness of insurers to pay claims from out-of-network providers especially if no alternative in-network providers are readily available.
- The applicability of any solution to changing health care delivery and payment mechanisms of the future

Any reasonable solution, however, will still require a degree of personal accountability and initiative on the part of the healthcare consumer, in order for them to exercise their right of free choice. As physicians, we need to provide them the information to make the financial, as well as medical, decisions that are best for them.

Anesthesia is one of the specialties most affected by this coverage and billing problem. Anesthesia bills are among those that lead to a patient's surprise. Anesthesiologists, in turn, have difficulty in these situations in receiving a fair compensation for the important services they provide.

We commend the Commissioner for this initiative and look forward to working with the Commissioner and department to devise a fair solution.