



PENNSYLVANIA  
society of  
ANESTHESIOLOGISTS

*Physicians Protecting Patients.*

February 26, 2016

The Honorable Teresa D. Miller  
Insurance Commissioner  
1326 Strawberry Square  
Harrisburg PA 17120

Re: *Insurance Department's Proposed Balance Billing Solution*

Dear Commissioner Miller:

I am submitting this letter as President of the Pennsylvania Society of Anesthesiologists (“PSA”) and on behalf of its approximately 2,000 physician members practicing throughout Pennsylvania. It is being sent in response to the Department’s request for comments regarding its January 19 proposed “Balance Billing” legislation. This letter discusses the practice of anesthesiology as it relates to provider networks, limits of insurance coverage, and the “balance billing” issue. It offers our comments on what the Department has proposed, including as requested possible revisions and alternatives.

Briefly stated, PSA concurs that surprise balance billing – when a patient receives a bill for medical services provided that is legitimately unexpected – is unfair to patients and should be addressed. PSA's central concern is that the solution will treat the symptoms and not the disease. Balance billing, particularly in the context of non-emergency care,<sup>1</sup> is primarily a symptom of an unduly narrow provider network and secondarily lack of information and understanding of health insurance by health care consumers. The number of insured consumers, and particularly newly-insured consumers, has increased with implementation of the Affordable Care Act (the “ACA”). Although the provider sends the bill, focusing primarily on the bill and the health care provider who provided the care and sent the bill looks at the wrong place and entity. We believe strongly that a network that does not include the hospital-based specialists that most in-patients will

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<sup>1</sup> The ACA, 42 U.S.C. § 300gg–19a(b) and 29 U.S.C. § 1185d, and related regulations, 45 CFR § 147.138(b)(3), effectively require insurers to cover non-network emergency care, essentially making billing in those situations much less of an issue for state legislation.

encounter cannot be deemed adequate, *i.e.*, it lacks a sufficient number and range of providers by class, specialty and geographic service area to adequately serve enrollees.

While it may be necessary in the short term to address the balance billing issue, to do so without addressing its root causes is “poor medicine.” Adding to our concern is genuine uncertainty, again primarily in the non-emergency context, as to the extent of the problem. We believe insurers are likely to have information on the extent of non-network claims (which may vary dramatically among insurers) and we respectfully suggest that the Department consider a data call to obtain it before legislation is finalized.

### **The Practice of Anesthesiology:**

Anesthesiologists, first and foremost, are physicians who have completed residency programs, typically four years in length, in the specialty of anesthesiology. Some may have completed a fifth fellowship year. Most PSA members provide surgical anesthesia services, which are among the several physician services (along with radiology, pathology (laboratory medicine), neonatology, and hospital medicine) that the Department’s proposed legislation identifies (definition of “Affiliated Service”).<sup>2</sup> Anesthesiologists provide essential services to hospitalized patients, including those seriously injured persons undergoing surgery under emergent circumstances. Even in non-emergencies, anesthesiologists typically do not meet their patient until the day of surgery and then in a setting not conducive to discussions of insurance coverage. Anesthesia services are a covered service under almost any conceivable health plan, as are the services of the other hospital-based specialties referenced above. As we discuss below, the services of all of these specialists are included within the “essential medical benefits” that the ACA mandates insurers provide.

Anesthesiologists almost universally practice in groups. At university hospitals and sporadically in other settings, anesthesiologists will likely be employees of the hospital-based health system. When they are not, such as at community hospitals, the group of which they are a member typically has contracted with the hospital to provide, on an exclusive basis, all necessary anesthesia services. When employed by a hospital, it is almost certain that an anesthesiologist participates in all of the same insurance plans and networks as the hospital. In the non-employee context, anesthesia groups almost universally negotiate with insurers as a group, and participation will be on an “all or none” basis. Some Pennsylvania hospitals and ambulatory surgical facilities, as a condition for medical staff membership, require anesthesiologists and, indeed, all physicians on their medical staff to participate in all insurance plans in which the hospital participates.

Interestingly, at least several of the hospital-based providers often pinpointed as involved in this issue – radiologists and pathologists – operate in similar fashion when they are not hospital

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<sup>2</sup> Some fewer anesthesiologists function as pain management specialists, usually on an out-patient basis, and would be less likely to be involved in the billing issues discussed here. Still other anesthesiologists work in critical care on an inpatient basis and they might encounter the billing issues here.

employees. Thus, the “all or none” participation model would likely apply to them as well. A network that lacks an in-hospital clinical laboratory is as deficient as one that lacks an anesthesiologist.

### **Reimbursement of Surgical Anesthesia Services**

Reimbursement for anesthesiologists differs somewhat from other specialties. While many specialties have hundreds of billing codes reflecting different services they provide, surgical anesthesia has essentially one: the anesthesia conversion factor. The conversion factor is a dollar figure that is multiplied by the total “anesthesia unit value” incurred in a given surgery. The anesthesia unit value is calculated from the time spent on anesthesia (one unit for every 15 minute increment), and certain non-time factors (often referred to as “base units”) that relate to the complexity and intensity of the anesthesia services provided.<sup>3</sup> There are nuances to be sure, but the central reimbursement issue is the value of the conversion factor; it is almost the only substantive financial issue involved in negotiations between an anesthesiologist practice and third party payors.

This leads, however, to a peculiarity in anesthesia reimbursement. For almost all other specialties and procedures, Medicare reimbursement is generally consistent with or higher than the reimbursement in the private managed care market. Anesthesia is the exception. Indeed, the Department has recognized this variance in 2004, in promulgating the regulation at 31 Pa. Code § 167.2. In doing so, the Department found both that Medicare reimbursed anesthesia care far less than did the managed care market and that it did so uniquely among the various medical specialties. At issue was the fairness to anesthesiologists of using a Medicare-based reimbursement rate in the Workers’ Compensation Program. The Department determined that this system mistreated anesthesiologists and that a 63.2% multiplier – i.e., a conversion factor that was 163.2% of the then existing Workers’ Compensation figure – was needed to bring anesthesia reimbursement to a fair level in 2004. *See* Commissioner Koken’s more complete discussion at 34 Pa.B. 3255 (June 26, 2004) and 34 Pa.B. 6405 (Dec. 3, 2004).<sup>4</sup>

### **“Surprise Balance Billing” related to Anesthesiologists**

As we have alluded to earlier, the concept of “surprise balance billing” actually comprises bills arising in two very different sets of circumstances, akin to those set forth at § 301 of the Proposed Act. It specifically does not – and should not -- include situations where patients for

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<sup>3</sup> The “non-time units” are established on a nationwide basis by CMS and are almost universally accepted by anesthesia groups and private insurers.

<sup>4</sup> The proceeding that led to this regulation arose under § 306(f.1)(3)(i) of the Workers’ Compensation Act, 77 P. S. § 531(3)(i), which generally established a reimbursement level of 113% of Medicare. That provision also allowed the Commissioner, if she determined that the Medicare reimbursement for a particular provider group was not reasonable, to adopt a new, more reasonable, allowance. In determining reasonableness, the Commissioner was to consider the extent to which Workers’ Compensation allowances to other specialties deviated from their reimbursement in the managed care market.

their own reasons voluntarily choose a particular out-of-network provider. Analogously, the Proposed Act does not – and should not – cover bills that may be substantial in amount but result from coverage limitations in the insurance plan. The two categories are:

- (1) emergency services provided by non-network providers, whose networks may not extend to where an emergency arises; and
- (2) non-emergency services provided when some of a patient’s providers are in-network and some are not; in the most common iteration, a hospital is in-network but certain providers are not.

There are several important differences between these categories. First, it is generally the emergency itself (*i.e.*, the patient’s medical condition), and neither the insurer nor the patient, that determines where and by whom emergency services are provided. Second, it is unfair to criticize an insurer whose network does not include providers practicing outside the network’s geographic service area, but emergencies can and will occur there nonetheless. Third, emergency services are commonly more expensive than non-emergency services, primarily because of the need to staff emergency departments on a 24/7 basis; physicians respond to emergencies without regard to insurance and in dire emergencies before anyone has determined coverage. Fourth, how insurers are to cover out-of-network emergency services, including how they must, at a minimum, reimburse non-network physicians, is addressed by the ACA, 45 CFR § 147.138(b)(3);<sup>5</sup> the ACA does not address non-network issues as to non-emergency care.<sup>6</sup> Finally, in general, the non-emergency situation likely reflects either an insurer’s purposeful decision not to contract with a provider/provider group or an impasse about contract issues, most likely reimbursement, that has led to non-network status.

These are meaningful differences and they suggest that a “one-size-fits-all” resolution to this issue may be inappropriate. As to emergency services, the need to reimburse what is often complex and expensive care is paramount. As to non-emergency services, it is important that a resolution of the surprise balance billing issue not unfairly alter the market forces at play between insurers and providers and not force a physician to accept a reimbursement level that the physician has previously rejected (if offered) or, minimally, not agreed to. The Department’s proposal distinguishes between the two categories in § 303(d-e) Option 1. New York state

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<sup>5</sup> The ACA defines an “emergency medical condition” as:

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

The Proposed Act generally follows that definition.

<sup>6</sup> Whether the ACA reimbursement rules preempt conflicting state rules is an open question.

regulations recognize this difference, excluding emergency services from the definition of “surprise balance billing.” See 23 NYCRR §§ 400.4 and 400.5(a-b) (distinguishing between them as to insurer’s responsibility).

Insurers, particularly given recent consolidation in the industry, are almost always much larger entities than the physician groups with which they are negotiating, giving them a significant market advantage. The primary leverage anesthesiologists (and providers generally) have in negotiating reimbursement is to not provide their services to an insurer’s policyholders at a reduced rate. The insurer’s substantial market leverage to exclude a provider or provider group is only limited somewhat by the concern that its network will lack sufficient providers in essential specialties, a fact that should give rise to regulatory and marketing-related concerns.

In the absence of an agreement to accept less than their usual and customary charge, physicians have a right to charge and receive that amount.<sup>7</sup> Physicians can agree to accept less via a provider contract, in return for other benefits. But they are equally free not to do so, particularly when they deem the reimbursement offered as insufficient.

These various market forces – or more likely the threat of deploying them – generally leads to an agreement between insurers and anesthesia groups. To the best of our knowledge, circumstances in which anesthesia groups do not participate with the major insurers in their geographical area of practice are infrequent. If, however, an anesthesia (or other specialty) practice is in-network with most but not all insurers, it seems relatively certain that the one(s) with which it does not participate has insisted upon terms and conditions of participation that vary from the others. It is important that a desire to protect patients not have the unintended and undesirable effect of allowing an insurer’s unreasonably low rates, rejected by the providers, to go into effect. Providers who have rejected network reimbursement levels at the negotiating table should then not be required to accept them for individual patients. To do so is to render participation negotiations meaningless.

### **Alternative Proposals and Approaches to the Patient Hardships Associated with Limitations of their Health Insurance Coverage and Out-of-Network Services**

As we noted at the onset, eliminating the root causes giving rise to non-emergency balance bill situations requires different “treatment” than addressing the symptoms, *i.e.*, bills for services from out-of-network providers. The latter requires a reimbursement standard and mechanism, the former a series of actions on the part of insurers and their regulators. The comments of the Pennsylvania Medical Society address certain non-reimbursement issues in detail and we strongly support those comments.

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<sup>7</sup> The Usual and Customary Charge is “[t]he charge most often made by providers of similar training, experience and licensure for a specific . . . product or service in the geographic area where the . . . product or service is provided.” 31 Pa. Code § 69.3.

## Network Adequacy

PSA believes that narrow provider networks, in which certain kinds of specialists (rather than certain individuals practicing that specialty) are not included, are at the heart of the problem. Concomitantly, PSA believes that robust provider networks would go a long way toward minimizing or eliminating the non-emergency surprise billing. The model mechanism to foster the creation of those networks already exists. PPO regulations, that are enforced by the Department of Health, 31 Pa. Code § 152.4(a)(2)(i), require PPOs to have a robust network: that there be “a sufficient number and range of providers by class, specialty and geographic service area to adequately serve enrollees and to provide them with adequate access to and availability of health care services covered under the preferred provider organization’s benefit plan.” A PPO network that has, as examples, no in-network anesthesiologists or pathologists practicing within a particular in-network hospital cannot possibly meet that criterion. A specialist at another hospital cannot provide the care.<sup>8</sup> PSA believes that this provision has not been applied in this fashion to date, but the authority certainly exists without additional legislation.

In this respect, the ACA, via its definitions of “essential health benefits” and “minimal value” effectively require this result. “Hospitalization” is, of course, one of the ten benefits mandated to be covered by policies sold in the individual/small group market. “Hospitalization” necessarily extends beyond room and board to include “Treatment in the hospital for inpatient care.” *See, e.g.,* <http://obamacarefacts.com/essential-health-benefits/>.<sup>9</sup> Covering those services requires insurers to have in place agreements to pay the providers of them. Both the 2014-16 and 2017 Pennsylvania Benchmark Plans (Aetna PA POS Cost Sharing 34 1500 Ded and Keystone, Gold Premier HMO, respectively,) cover both “Inpatient Hospital Services (e.g., Hospital Stay)” and “Inpatient Physician and Surgical Services.” Further, to avoid penalties, employer-provided health benefits must satisfy “minimum value” standards by providing “substantial coverage of inpatient hospital services.” *See* 45 CFR § 156.145(a).

Network adequacy should be evaluated before an insurance plan is approved for sale, and on a regular basis. The Department should require insurers to submit information on out-of-network care that would reveal the underlying causes. Greater than a fixed percentage of out-of-network claims for an insurer in any specialty or geographic area should trigger a review of that insurer’s

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<sup>8</sup> Analogously, 31 Pa. Code § 154.11 requires managed care plans to allow patients with serious medical conditions either to have a standing referral to a specialist with expertise in treating the patient’s condition or designation of a specialist to coordinate care. That provision could be interpreted, or revised if deemed necessary, to require the managed care plan to have in place appropriate specialists for an in-patient. Clearly, specialists for a hospitalized patient must provide care at the hospital.

<sup>9</sup> More fully, “hospitalization” includes “Care you receive as a hospital patient, including care from doctors, nurses and other hospital staff, laboratory and other tests, medications you receive during your hospital stay, and room and board. Hospitalization coverage also includes surgeries, transplants and care received in a skilled nursing facility ....” *See, e.g.,* <http://obamacarefacts.com/essential-health-benefits/>.

network adequacy by the Department of Health. For tiered networks, this adequacy must be demonstrated for all tiers, including the lowest cost tier.

### **Network Transparency**

As a less desirable alternative to robust network requirements, insurers should be required to advise consumers, in useful ways, of the “holes” in their networks.

PSA believes that insurers need to disclose affirmatively when their networks include a hospital but exclude the specialty services (anesthesia, labs, radiology) that a patient can be expected to utilize during a stay. This information should be affirmatively stated, both as to what services are in-network and those that are not. Patients cannot be expected to know what types of providers (other than their admitting physician and/or surgeon) will likely care for them, but insurers can have access to this information.

State law, 40 P.S. § 991.2136(a)(14), requires managed care plans to list by specialty the name, address and telephone number of all participating health care providers. The problem is that a listing of that kind, unlinked to a hospital where those persons practice, provides information that is not organized so as to be useful in this context. PSA suggests that the Department consider revising and broadening the scope of that provision so that it becomes useful to consumers. Similarly, it might be appropriate to place some of that responsibility on a hospital, which likely knows (as individual physicians would not), which providers within the hospital are not part of the patient’s network. Adequate disclosure should eliminate surprises, except of course for true emergency services. Many insurer networks provide information on “expected cost of care.” That would be an appropriate place to advise prospective patients that the patient might receive care from identified specialties that are non-network and to identify the expected costs of non-network services.

### **Ancillary Insurer Reforms**

PSA believes that some insurers have policies that permit a patient’s assignment of claims to out-of-network providers from their insureds but leave it to their discretion to honor it. That provision serves no legitimate purpose and should be replaced with a mandatory “honor assignment” provision and pay assigned claims directly to the provider, whether in or out of network.

A health insurance plan’s annual individual and family out-of-pocket maximum payments should also include balance billed charges that a patient has paid directly to providers. When a portion of a provider charge is beyond the OOP maximum, the insurer must make the required payment.

### **Determining Health Care Provider Reimbursement**

Placing legislative limits on both a health care provider’s ability to determine their own charges for their services and their ability to fairly negotiate payment with insurers would then leave it to the proposed law to establish the “reasonable charges” or payments for health care services. As we have said previously, we do not support this approach, which would tend to use a “one size

fits all” approach to all of the primary care physicians, medical specialists, and health care facilities caring for patients in our diverse, rural and urban state. Almost any legislative mechanism to determine reasonable reimbursement will lead to disparities and disruption in the health care marketplace. We would want to be particularly sure that any legislatively-established payment mechanisms would create conditions 1) encouraging the negotiation of participation agreements between insurers and providers by providing incentives to both to negotiate as well as a level playing field allowing negotiation, and 2) not lead to payment disparities that would impose undue hardships on health care providers serving in the more financially challenging environments of rural and inner city Pennsylvania. However, if this legislative approach is chosen, both existing Pennsylvania law and legislation/regulations of other states provide guidance toward reasonable payment benchmarks.

PSA notes that current Pennsylvania law, now limited to PPOs, provides some helpful approaches, particularly regarding emergency situations. Under 31 Pa. Code § 152.15, a PPO “shall pay” for emergency health care services provided by a non-network provider so that the enrollee is not liable for a greater out-of-pocket expense than if the enrollee were attended to by a preferred provider or physician. That requirement necessarily requires the PPO to pay either the provider’s UCR (less standard copay and/or deductible) or some other amount agreed upon by the insurer and provider. Similarly, § 154.14 requires PPOs “to pay all reasonably necessary costs for enrollees” receiving emergency services and 40 P.S. § 91.2116 requires a managed care plan to “pay all reasonably necessary costs associated with” emergency care.

Recent “balance billing” legislation in other states uses benchmarks for determining what constitutes reasonable payment to health care providers. California requires that health insurance plans pay non-network providers of emergency services a “reasonable and customary” value for that service. That value must be based on “statistically credible information that is updated at least annually” and that takes into account factors such as the provider’s training and experience, the nature of the service provided, and fees usually charged by a provider. [Cal. Code Regs. tit. 28, § 1300.71(a)(3)(B-C)].

Florida statute, [Fla. Stat. Ann. § 641.513(5)], requires HMO plans to pay providers the lesser of the provider’s charges, the usual and customary charges for similar services in the community, or a charge mutually agreed to by the plan and the provider. Texas law, [Tex. Admin. Code tit. 28, § 3.3725 (e)] requires that when out-of-network services are provided in an emergency or because of an inadequate PPO network, the PPO pay at least the usual and customary rate for the services in the area.

Finally, New York, in legislative changes made in 2014 to address many similar problems, requires health plans to establish a reasonable payment amount for providers. Plans must disclose their methodology for establishing the payment amount and how it compares to usual and customary costs, which are defined as “the 80th 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”. See 23 NYCRR 400.2(v).

These provisions suggest that a legitimate benchmark for out-of-network provider charges and payments would be the usual charges for the same service in the same geographic area, by providers in the same category or medical specialty, based on statistically credible, broad-based, and current data from an independent database selected by the Insurance Commissioner. This general approach would provide an ongoing incentive and flexibility for both insurers and providers to negotiate participation agreements while eliminating inordinately large charges that currently present patient hardships and increase costs. Further, we anticipate though of course cannot prove, that these “usual charges” will gradually decrease with the implementation of current and future payment reforms.

As noted earlier, the Department has recognized that a Medicare-based system treats anesthesiologists uniquely and unfairly. The Department solved the problem as to Workers’ Compensation but Medicare reimbursement for anesthesia care remains an aberration. The 2015 Workers’ Compensation conversion factor ranged from \$49.13 to \$55.15 by region of the state. *See* [www.portal.state.pa.us/portal/server.pt/community/fee\\_schedule/10424](http://www.portal.state.pa.us/portal/server.pt/community/fee_schedule/10424) (Part B tables for PT/HCPC 100-1999.) Private market conversion factors are even higher. In contrast, the Medicare conversion factors for 2016 are \$23.11 for the Philadelphia area and \$21.47 in the remainder of the State. *See* <https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html>.

PSA does not, of course, expect the Commissioner to remedy the problem with Medicare’s reimbursement of anesthesia services. What is important is that Pennsylvania, having recognized the inequity of imposing a Medicare-based-system for anesthesiologists, not reinstate such a system. If there is to be a Medicare-based system for some providers, there needs to be an alternative data base or carve out for anesthesiologists or the Worker’s Compensation fee schedule, which modifies Medicare to make it fair, would need to be used instead. If that is not done, the surprise billing issue will be “resolved” as to anesthesia care by grossly under-reimbursing anesthesiologists, raising longer term concerns about access to these important services.

### **Arbitration**

The Department has included in its proposal, and requested comments on, two arbitration systems to be used when insurers and providers cannot reach agreement. Similar legislation in most other states also includes arbitration provisions. PSA agrees that arbitration has a real place for unusual situations containing unique circumstances that require individual consideration. However, arbitration is time-consuming and costly, particularly in light of the amounts usually at issue. As mentioned previously, most insurers are much larger and have considerably more resources than physician groups. They also have access to much more comprehensive data than providers. Therefore, PSA believes that arbitration for individual cases will in general be unfairly burdensome to health care providers, and should not be relied upon to be a common means of dispute resolution.

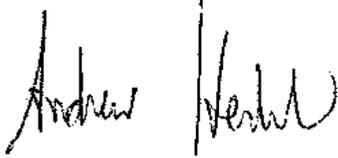
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Thank you for your consideration of these materials. We are anxious to continue working with you to develop this proposal into a comprehensive legislative solution to the problems associated with payment of out-of-network health care providers.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew Herlich". The signature is written in a cursive style with some loops and flourishes.

Andrew Herlich, MD

cc: Jessica Altman, Chief of Staff  
David Buono, Consumer Liaison  
Glenda Ebersole, Policy Director  
Sandra Ykema, Esq., Department Counsel  
Donald Martin, MD, PSA Board Member  
Robert Hoffman, PSA Counsel