Pennsylvania Society
PSOH
Oncology and Hematology
A Multidisciplinary Organization

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February 29, 2016

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

Re: Pennsylvania Society of Oncology and Hematology comments on the Pennsylvania Insurance Department's (PID) Balance Billing Legislation – Proposed DRAFT 01-19-16

Dear Commissioner Miller:

Thank you for the opportunity to comment on your draft proposal to address so-called "surprise" billing. On behalf of the physicians and other health care professional members of the Pennsylvania Society of Oncology and Hematology (PSOH), we are particularly focused on the adverse effects we anticipate from the proposal as it relates to the care of patients with blood disorders and cancer. While we have significant concerns about the draft legislation, we are interested to work with you to address this issue.

PSOH fully understands the consumers' perspective and the unfairness of making every attempt to access in-network care at participating facility, only to be billed by a non-participating provider. Moreover, we strongly oppose excessive billing practices by physicians that can result in significant financial burdens on patients and seek to distance ourselves from the very rare provider that exploits their out-of-network status.

Below are our suggestions to refocus the legislation in a way that fully protects patients and offers fairness to providers and health plans.

Fair and independently-established out-of-network allowables

Our primary concerns with the draft centers around the impact we believe it would have on the market and the ability of providers to negotiate fair contracts. As you know, a delicate balance of power exists between insurers and health care providers during contract negotiations that ideally results in adequate networks and competitive payments to providers. We fear that this proposal would disrupt that balance by taking away the negotiating power of providers.

By setting the rates for many providers who do not contract with insurers at a percentage of Medicare rates or the average in-network rates – rates that do not accurately or fairly reflect the cost of care – the draft legislation would eliminate incentives for insurers to contract with physicians on financially and ethically viable terms. As a result, providers would come to the table with no leverage because they receive the same payment (or less) if they do not reach an agreement.

Moreover, we find ourselves at a time when insurers are structuring their networks to be very narrow. We fear that creating a market where little difference exists - from the insurer's financial perspective - between contracting and not contracting with certain providers will result in very restricted networks for consumers.

To provide fairness and balance, it is critical that insurers base their payments to nonparticipating providers on usual, customary and reasonable (UCR) rates using out-of-network charge data from an independent source. Fair Health (www.fairhealth.org), a national, independent, health care database, is, in our opinion, the best option for data to establish independent UCRs.

Network adequacy standards

In addition to a charge-based UCR, we suggest that the proposal include new requirements for network adequacy. The first line of defense against out-of-network bills should be a regulatory framework that fosters adequate networks that provide patients with timely access and choice. Critical to this are strong, measurable network adequacy standards that include evaluation of patients' ability to access participating providers at participating hospitals.

Unfortunately, too often a weak network will be able to meet network requirements under the federal or state standards without showing coordination of providers and hospitals. For example, a plan may have hospitals A, B and C in their network and 20 pathologists contracted with the plan, but only one of those pathologists has privileges at hospital C. As a result, it is likely that a member of that plan who is taken to hospital C will receive care from an out-of-network pathologist.

Given the call to address so-called "surprise billing," PSOH implores policymakers to require special 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.

Transparency in out-of-network coverage

PSOH also calls for increased transparency for patients. Consumers who purchase PPO products pay more in premiums to have the health insurer cover a portion of the cost of accessing any physician because the choice of physician is highly valued. Unfortunately, that coverage is rarely as comprehensive as believed and patients simply do not receive value for the higher premiums paid.

Transparency in out-of-network coverage is an essential first-step in helping patients determine whether it is cost-effective for them to pay those higher premiums and if they will truly receive the coverage advertised. At the most basic level, to understand their financial responsibility, patients need to know how much a nonparticipating physician will charge for care and, in turn, how much their insurer will pay for that care. 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.

Unfortunately, the current trend of using "non-UCR" methods of determining nonparticipating physician payment prevents consumers from having a clear idea of how much of the nonparticipating physician's bill the health insurer will pay, and how much of that bill will remain the patient's financial responsibility.

Physicians should voluntarily inform patients regarding fees and discuss their out-of-network fees in advance of services whenever possible, and PSOH strongly encourages all physicians to do so.

Patient out-of-network costs count toward out-of-pocket maximum

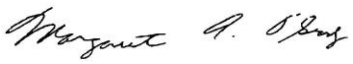
Finally, the Affordable Care Act created important stopgaps for out-of-pocket costs to patients, as it established individual and family maximums. However, at insurers' discretion, maximums usually do not include the out-of-pocket costs for out-of-network care, leaving the patient still vulnerable to significant, unanticipated health care expenses.

Given the shift toward narrow networks that result in more frequent use of out-of-network providers, PSOH strongly encourages policymakers to 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.

Summary

PSOH urges you to take the above steps to provide fair and independently established out-of-network allowable charges, set network adequacy standards, require transparency in out-of-network coverage, and institute that patient out of-network costs count toward out-of-pocket maximum. These measures will strengthen the proposal and help protect vulnerable patients with blood disorders and cancer whose disease necessitates assured and timely access to affordable care. Your consideration is appreciated. For further information please contact Robbi-Ann M. Cook, PSOH Executive Director, 717.909.2688, rcook@pamedsoc.org.

Sincerely yours,



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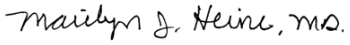

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