Pennsylvania Medical Society

Pennsylvania Medical Society Testimony
Out-of-Network Billing
October 1, 2015

Good afternoon Commissioner Miller. Thank you for inviting the Pennsylvania Medical Society (PAMED) to testify on this very important issue facing both consumers and providers. As someone who also has firsthand experience with being an out of network provider, I also have a unique perspective on this issue.

The mission of PAMED is to advance quality patient care, the ethical practice of medicine, and advocating for the patients we serve. It is truly the business of the physician community to improve people's lives. It is in our nature to accept an emergency call at 3 AM, often waking up our spouse and children, and leaving them to drive to the hospital to help a patient in their time of need. In my personal world, it may be a 40 year old father of two who is having an acute stroke, whereby he can no longer move the right side of his body and cannot speak without medical intervention. As a physician on the front lines, at the bedside, learning about and being touched by patients' stories every day, physicians are the last ones who would ever want to see harm come to a patient in any way, medically or financially. As we hope you will see, the issue of out-of-network billing is either due to a situation out of the physician's control or truly as a last resort, when the physician is against the proverbial wall. Further, this issue is not new, but remains unresolved and we hope to work with you to solve this problem.

We would like to provide our clinical insight, knowledge and expertise on these important issues before us today as this discussion moves forward.

First, we want to examine why providers may not be participating with health insurers in the first place. In recent years, many insurers and employers have been moving toward "narrow networks."

777 East Park Drive

PO Box 8820

Harrisburg, PA 17105-8820

Tel: (717) 558-7750

Fax: (717) 558-7840

Email: stat@pamedsoc.org

www.pamedsoc.org

With the information gleaned from our practice support department on member calls, we have seen physician providers excluded from networks without "cause." It may be something as simple as being a solo practitioner that excludes them from network participation. In some cases provider terminations are occurring unbeknownst to either the provider or their patient. PAMED has been informed recently of an OB/GYN practice that was terminated from a major national insurer but was never told they had been terminated. The patient continued to use this provider as they thought the provider was in-network. After several weeks, the provider began seeing their claims submitted to the insurer rejected. It took rejection of claims from the insurer, for the provider and their patients to realize that the care which had been provided was out-of-network.

Narrow networks also mean more patients end up going out-of-network (whether due to necessity or choice), further exacerbating the problem.

Second, health insurer consolidation can lead to the exercise of market power by insurers in the purchasing of physician services. Market power in input markets is known as monopsony power—the ability to reduce and maintain input prices below competitive levels. The movement of providers' payment levels below Medicare (especially in rural communities) is a real example of payment issues that exist in Pennsylvania. The exercise of monopsony power can reduce the quantity and quality of health care below competitive levels and in turn harm consumers.

An annual study of health insurance markets conducted by the American Medical Association, has demonstrated that a number of Pennsylvania health delivery markets are dominated by just a few commercial insurers. Let's look at a couple of communities in Pennsylvania. The Erie community has one insurer controlling 72% of the market; in Altoona it is 67%; in Johnstown it is 68%; and in Philadelphia it is 55%. As we stated, monopsony power can influence network composition through no cause exclusions as well as payment rates that are inadequate. Recent research provides evidence that insurer consolidation leads to the exercise of monopsony power in the form of lower physician earnings and employment.

It is no secret that our communities' need for physicians continues to grow while the supply of physicians remain inadequate in some communities. Low compensation from commercial insurers risk community access to physicians and as well as quality care. It was not too long ago when my practice interviewed a young candidate for a position and we were turned down solely because he could garner an additional $50,000 yearly by accepting a position in a different state.

Most Pennsylvania physicians are unable to negotiate with commercial insurers due to presence of monopsony power. As a result, physicians face hard choices -- leave the state to practice in more lucrative geographies, change careers, retire early, or become employed by larger systems and hope for higher rates.

Now, back to the issue at hand, out-of-network billing. The varied approaches states have taken to solve this problem generally fall within two sets of protections. First, they do not require active intervention by the consumer. Second, they have a mechanism, acceptable to both insurers and providers, for determining the amount of payment, disbursed directly to the provider.

For consumers, transparency provisions need to be adopted that encourage data disclosures to highlight problem areas. For example, members of Blue Plans in Pennsylvania cannot assign their payment benefit directly to the out-of-network provider. Therefore, the provider is left with no choice but to expend additional administrative costs to seek payment directly from the patient. These payments are often not transferred as intended even though they were meant for a certain provider. This approach is not supportive of collaboration and indeed may contribute to the challenges that brought us to this discussion. I can personally attest that this is a significant problem in our Commonwealth. Legislation or rulemaking that would require direct payment to an out-of-network provider may encourage that provider to accept payment at the Fair Health rate for example.

In an emergency situation, emergency department providers must screen and treat the patient under rules from EMTALA regardless of insurance. Everyone who presents to the emergency department gets treated the same way. Patients may choose to use the closest emergency department for their care instead of the nearest participating emergency department. Of course, in the setting of an emergency, patients are likely less cognizant of who is in network. Physicians should not be penalized for these types of patient decisions. Furthermore, physicians sometimes need to consult other physicians in hospitals, particularly inpatient emergencies. In these situations as well, the same problem may arise. We should not put the burden on the patient to decide if they will accept a provider's care at a time when they are suffering from mental or physical ailments and truly may not have a choice as that provider is the only one available in the community to assist that patient at that time.

Lastly, many physician specialists are "on call" at their hospital. Physicians pulled away from their practice to attend to emergency situations also lose money as office-based patients with insurance the specialist does participate in now cannot be seen.

Again, as a last resort, health care providers need to have the ability stop participating with commercial insurers if reimbursement levels are low enough that the provider cannot maintain one's practice. However, communities must also still have access to providers.

We recognize that emergency care and surprise billings can be a financial hardship on consumers. In a setting where services are required and the patient may not have a choice in care, we would hope that insurers would compensate these specialists through a fair, direct, reimbursement methodology.

PAMED stands ready to work with the Insurance Department and other stakeholders to find a solution that protects consumers and treats providers and insurers fairly.

Thank you for the opportunity to provide comments on this critical issue affecting citizens of the commonwealth. We are available to answer questions or field any comments you may have about our position.

Brad Klein, MD, MBA
Pennsylvania Medical Society