

Statement of The Hospital & Healthsystem Association of Pennsylvania

For the

Pennsylvania Department of Insurance

Submitted by

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My name is Jeff Bechtel and I am the senior vice president for health policy and economics for The Hospital & Healthsystem Association of Pennsylvania, or HAP. HAP represents and advocates for nearly 240 acute and specialty care hospitals and health systems across the state. We appreciate the opportunity to discuss how HAP and Pennsylvania hospitals are working to promote transparency in patient billing.

The issue of balance billing is very complicated, and we applaud the Department of Insurance for scheduling this hearing to investigate the scope of the problem, hear the perspectives of consumers and other stakeholders, and begin to explore possible solutions.

Health insurance has grown more complex, and more people have health insurance than ever before. These complexities include new insurance product designs, such as tiered and narrow networks that involve higher out-of-pocket costs for consumers if they see providers that are considered a less preferred tier or out-of-network. This can result in increased deductibles and/or copays for the patient. In addition, health insurers contract separately with health care facilities and physician groups, which means that not all physician groups that provide services in the hospital setting will participate with the same insurance products as the hospital. All of these factors—and others—make it more and more difficult for consumers to navigate the system.

To help address this complexity, 70 percent of Pennsylvania's licensed, general acute care hospitals have adopted the attached *Principles and Operational Guidelines for Consumer-focused Hospital Financial Services*. These principles demonstrate the commitment of the hospital community to ensure that consumers have a better understanding of their financial responsibilities, and ways to get assistance to meet those responsibilities, if needed. I should note that these principles are based upon national best practices developed by the Healthcare Financial Management Association and the American Hospital Association.

These principles recognize that, as consumers become more involved in making decisions about their medical care, they need and deserve up-front information about their financial responsibility. The goal is to eliminate surprises and help consumers navigate a complex billing system that involves many parties, including insurance companies, physician practices, hospitals, employers, and government entities.

Hospitals and health systems are at various stages in implementing these principles, but they all are committed to integrating transparency practices and adopting technology, such as customer billing estimators, to enhance the consumer interaction about financial issues.

While HAP has worked with its members to take steps to improve transparency, the unexpected balance billing of patients following a medical procedure continues to be an area of concern for HAP. The problem arises when the hospital is in-network, but other hospital-based physicians providing care are not, for example, an emergency department physician, anesthesiologist, or radiologist.

Some patients may choose to receive services out-of-network, and expect to be balance billed for these services. Others are at risk for unplanned out-of-pocket costs when hospital-based physicians do not participate in the same networks as the hospital, attending physician, or surgeon providing services at that hospital.

This may occur for several reasons. An insurer may not be willing or able to negotiate network contracts with hospital-based physicians; or a physician may choose not to contract with the plan, or may not accept an offer of employment from the hospital. There are numerous permutations. Due to these circumstances, there are often out-of-network physicians practicing at hospitals.

The nature of these services and the need to provide 24/7 availability is such that it is difficult to know with certainty which hospital-based physician may provide services to any given patient at any given time. For example, one surgery that lasts longer than expected can cause a last-minute change in the anesthesiologist for a second surgery. Illness or other emergencies can cause similar last-minute substitutions. When any of these circumstances occur, the patient can end up receiving care from an out-of-network physician, resulting in a surprise bill from that physician.

Based on our review of this issue and the policy solutions pursued by other states, we have learned that there is not a “silver bullet” solution. We do know that in order to solve this problem, there must be a shared responsibility among insurers, health care providers, and physicians to work together to make this easier for patients. While we are not yet in a position to offer recommendations, we can provide general observations that may help the deliberations moving forward.

- Some advocates may suggest that hospitals enforce a prohibition of any balance billing by hospital-based physicians who are not in-network. This is not feasible from a practical perspective since these physicians, while based in the hospital, are not employed or under contract with the hospital. Any policy efforts that head in this direction may inadvertently cause access issues by discouraging the provision of care.
- Proposals to set “default rates” also are problematic. Intervening in negotiations between providers and insurers and “picking sides” may—depending on the approach—either serve to drive up costs or make it difficult or impossible for insurers to build networks.
- Some states have adopted an arbitration model, which removes the consumer from the dispute. This model undoubtedly will be evaluated, and merits consideration.
- Payment reforms being developed by Medicare, Medicaid, and commercial insurers to better integrate care through bundled payments for a service, which eliminate separate

bills by facilities and practitioners for an episode of care, are likely to reduce surprise billings.

- The strict enforcement of state network adequacy requirements, which would serve to ensure a stronger in-network array of services, also may be part of the solution.

In conclusion, this is a complicated problem for consumers and the health care system. HAP is committed to working with the Department of Insurance, consumers, and other stakeholders to address the issue. Thank you for the opportunity to comment during today's hearing.

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