COLLEGE of AMERICAN PATHOLOGISTS

Statement for the Record
United States House Committee on Energy and Commerce
Subcommittee on Health
No More Surprises: Protecting Patients from Surprise Medical Bills

June 12, 2019

Statement by
College of American Pathologists

The College of American Pathologists (CAP) appreciates the opportunity to share our comments in response to the committee's hearing on surprise out-of-network medical bills. We appreciate the discussion of this important issue so that all stakeholders can work together to protect patients and ensure continued access to high-quality health care. The CAP has been constructively engaged on this issue for many years. It has always been our position that patients should not be financially penalized for the failure of health insurance plans to provide in-network access to hospital-based physician specialties.

As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide. The CAP believes that to protect patients from gaps in their health insurance coverage, insurers and providers should settle all payments without the patient's involvement, even if an independent arbitrator settles disputes. Network adequacy standards for health plans should be set, and at a minimum, there should be network standards for ensuring that an appropriate number of specialty physicians are available to provide medically necessary services at "in-network" facilities. Additionally, it is critically important that out-of-network payment mechanisms not in any way deter, displace, or discourage equitable contracting for physician services, as we believe such contracting is critical to maintaining the private commercial marketplace that consumers wish to avail. Finally, any reimbursement for out-of-network services should be based on the market value of physician services according to commercial data compiled by independent, non-affiliated organizations, like FAIR Health Inc. or a state's all-payor claims database (APCD). For these reasons, we urge a fully deliberative and engaged physician specialty stakeholder process, as has occurred to date in multiple states, to produce an optimal legislative outcome that protects patients and preserves the non-governmental health care marketplace.

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Remove burden of surprise bills from patients

Limiting unexpected patient cost sharing is an essential part of any congressional action. Through no fault of their own, patients are caught off guard when an insurer doesn't cover certain physician services. Patients do not need additional financial stress when they are at their most vulnerable. Congress should create a system whereby insurers and providers can come to agreement independent of the patient, who should only pay for care at an in-network rate.

Alternative dispute resolution (ADR) can help address this problem when set up appropriately. If there is a dispute over payment between an insurer and provider, an independent arbitrator can step in and consider several factors pertaining to the case. An arbitrator should be able to consider things like complexity and duration, but also other factors that either the insurer or provider may submit. Parameters that include geographically-based charges by providers and payments from insurers should be used in order to determine the fair market value of the physician service. It is imperative that in-network rates not be an exclusive factor in determining a starting point or an outcome for any arbitrator, as this would immediately bias the process and defeat the goal of the ADR option.

Several states have policies that protect patients from out-of-network bills resulting from gaps in health insurance plan contracting. States with laws that are reasonable and that appropriately protect patients include: Arizona, New Jersey, Maryland, Massachusetts, Illinois, Minnesota, Florida, Washington, and New Hampshire.

In particular, the law enacted by New York State is the optimal approach to protect patients from surprise medical billing. In New York, patients are financially held harmless and there is an effective method for resolving disputes between providers and insurance plan payers. Further, not only is there mediation/arbitration between insurers and providers, but the payment methodology upon which the "usual and customary rate" (UCR) is calculated is based upon the 80th percentile of FAIR health database charges to reflect the market value of physician services. Most importantly, it is clear this approach is working. Researchers at Georgetown University recently determined that ''insurer, provider, and consumer stakeholders generally agree that the implementation of New York's Surprise Billing law went smoothly, was relatively fair to all parties, and is working as intended to protect consumers from a significant source of financial hardship."[1] The Georgetown study also notes that state officials have reported a dramatic decline in consumer complaints about balance billing and physicians are largely satisfied with the process and its results. Finally, concerns about inflated charges are thus far proven unfounded, as the Georgetown researchers cited a study that found

[1] https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9

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a 13 percent average reduction in physician payments since the law was enacted in New York.

Enact network adequacy standards

The CAP strongly believes inadequate networks are the root cause of surprise bills. Unfortunately, many of the legislative proposals released do nothing to address the issue. Without adequate networks of contracted physicians, a patient cannot be properly guarded from out-of-network health care at an in-network facility. If there are fewer out-of-network providers to begin with, there will be fewer patients receiving their bills.

It is important to recognize that the vast majority of providers, including pathologists, wish to contract with health plans. Health plans have deliberately and systematically denied network participation to, or ejected pathologists and clinical laboratories from network participation, and states are starting to take notice. In December of 2017, the Washington State insurance commissioner fined a health insurer $1.5 million and detailed steps it must take to fix its provider networks. Most recently, in Texas, the Center for Public Policy Priorities reported in 2014 that one health plan in the state had no pathologist providers at 20 percent of their in-network hospitals. Then, in October 2018, this health plan was fined $700,000 by the Texas Department of Insurance for failure to contract with a hospital-based physician specialty in multiple counties.

The CAP supports federal enactment of network adequacy requirements similar to the law of Louisiana (Network Adequacy Act 22§1019.1 et seq,) that expressly require health insurance plans to “maintain a network of providers that includes but is not limited to providers that specialize in mental health and substance abuse services, facility-based physicians, and providers that are essential community providers.” Facility-based physicians are defined in the Louisiana Act to include: “anesthesiologist, hospitalist, intensivist, neonatologist, pathologist, radiologist, emergency room physician, or other on-call physician, who is required by the base health care facility to provide covered health care.” Such requirements should be subject to regulatory oversight and enforcement to ensure that patients have reasonable and timely access to in-network physician specialists at in-network hospitals and facilities. California (Code of Regulations (CCR) Title 10, Section 2240.5 (d) (14)) and New Hampshire (RSA 420.J:7 II(e)) are two other states with specific hospital-based physician network adequacy requirements. However, at present, the vast majority of states have no such hospital-based physician network adequacy requirement and thus should be compelled under federal law to adopt such requirements.

Of note, transparency alone cannot solve the surprise bill problem for patients, as many physician services are unexpected and cannot be anticipated by the patient. For example, the type of specimen or complexity of the analysis done by the pathologist is often not known in advance of the initial microscopic analysis, making it impossible to provide a reliable estimate of charges or costs. Moreover, patients under anesthesia during a procedure cannot exercise choice or control over pathology or laboratory

referrals. Thus, creating regulatory standards that require health insurance plans to contract with the requisite number of providers covering the full array of physician care at an in-network facility, including pathology and laboratory services, is a more appropriate component of the solution to reduce surprise bills.

Fair reimbursement for out-of-network services

In order to encourage health plans to contract for physician services, and to ensure that the health care delivery system is financially viable, a fair market rate should be paid for physician services. In general, caps on payment for physicians treating out-of-network patients should be avoided. If pursued, guidelines or limits on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database.

Further, if in-network rates are used as a benchmark for payment, insurers have a clear economic incentive to lower rates without any constraint and have the unilateral ability to do so.

Several proposals from Congress rely on a median in-network rate to determine payment to providers delivering care to out-of-network patients. **The CAP opposes the use of a rate that can be wholly controlled by the health insurance industry**. In the end, it is important to remember that it is doctors who care for patients, not insurance companies. Any prohibition, whether state or federal, on out-of-network billing should be paired with a corresponding payment process that is keyed to the market value of physician services.

A caution regarding price transparency

A lack of information about the cost of health care services can be an impediment to transparency and patient empowerment, but the CAP generally opposes adding additional administrative requirements on physicians that interfere with or impair the patient's medical diagnosis and care. Transparency alone cannot solve the surprise bill problem for patients, as many physician services are unexpected and cannot be anticipated by the patient.

Specifically, we wish to emphasize the unique difficulty that pathologists have in providing patients with information about out-of-pocket costs in advance of services. For instance, a surgical or invasive diagnostic procedure performed by a dermatologist, surgeon, gastroenterologist, urologist, or other clinician may result in no specimens obtained or it may result in multiple specimens requiring anatomic evaluation. Additionally, anatomic pathology services typically involve a pathologist performing microscopic analysis of tissue or body fluids to determine whether cancer or other disease is present and, if so, its characteristics. The type of specimen or complexity of the analysis is often unknown in advance of the initial microscopic analysis conducted by the pathologist, making it impossible to provide a reliable estimate of charges or costs.

Providers should be transparent about their own anticipated charges at the time of scheduling, and insurers should be transparent about the amount of those charges they will cover. However, in going any further, the difficulty of price transparency poses administrative hurdles and significant risk for patient harm from any delays.

Summary

As the committee moves to address the issue of surprise billing, it is of paramount importance to strike a compromise that holds patients harmless but also allows providers and insurers to come to agreement on outstanding bills. The CAP would be supportive of a legislative proposal that includes:

1.) Language that holds patients harmless and enacts a process, like ADR, that allows insurers and providers to settle any billing disputes without involving the patient;
2.) Network adequacy standards that ensure a proper number of physicians can provide services at in-network facilities; and
3.) If necessary, a payment benchmark that precludes the unilateral ability of health insurance plan to determine payment as would be the case with in-network rates. Instead, there must be a balance of geographic rates from an independent database to either inform an arbitrator in an ADR process or to ensure that the commercial value of the service is considered in determining payment.

Specifically, the CAP is supportive of the direction of the section-by-section legislative proposal released by Representatives Raul Ruiz, M.D., and Phil Roe, M.D., that addresses surprise billing. The solutions as proposed would take necessary steps to accomplish the goals of holding patients financially harmless from surprise medical bills while creating a fair reimbursement system that keeps patients out of the middle of billing disputes. The CAP is pleased to see inclusion of a baseball-style arbitration process that allows consideration for a range of factors, including the usual and customary rate that reflects the market value of physician services. Although the proposal does not address network adequacy, we appreciate that the proposal's goal of avoiding the use of a rate that could be wholly controlled by insurers.

Thank you for your consideration of this important issue and we look forward to working with your committee to come up with the best solution for ensuring patients have in-network access to physician services or are otherwise protected from out-of-network charges that result from health plan inadequacies. The CAP urges the committee to work with Representatives Ruiz and Roe on their proposal to address surprise billing. If you would like to meet, or have any questions, please contact Sarah Bogdan, Assistant Director, Legislation and Political Action, at Sbogdan@cap.org or 202-354-7106.

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