Statement of The Hospital & Healthsystem Association of Pennsylvania

Before the

Senate Public Health and Welfare Committee

Presented by

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Chair Vance and members of the Senate Public Health and Welfare Committee, I am Paula A. Bussard, Senior Vice President, Policy and Regulatory Services, for The Hospital & Healthsystem Association of Pennsylvania (HAP).

As you know, HAP represents and advocates for the more than 250 acute and specialty care hospitals and health systems across the state and the patients they serve. We appreciate the opportunity to provide a perspective on issues related to access and continuity of care when provider networks of a health plan are modified by either the health plan or the health care provider.

Background

Pennsylvanians count on health care being there when they or their family members need help. Hospitals and health systems play an important role in providing coordinated, high quality, compassionate health care to patients in communities across the commonwealth. Pennsylvania hospitals and health systems provide care to patients 24 hours a day, seven days a week and make every effort to treat all patients with dignity, respect, and compassion.

Pennsylvania 257 licensed acute and specialty care hospitals and health systems annually care for 1.7 million inpatients and 38 million outpatients; evaluate and treat more than 5.8 million injured and ill people in their emergency departments; and deliver more than 133,000 babies.

In cities and towns throughout Pennsylvania, hospitals are the cornerstone of the health care delivery system. Hospitals are there when Pennsylvanians give birth or die, are injured, or live with a chronic illness. Hospitals are there when disaster strikes and when there are no other places to turn—24 hours a day, seven days a week responding to the health care challenges in their communities. Hospitals provide care to all who need it, whether well-insured, underinsured, or uninsured. Pennsylvania hospitals take seriously the mission that is reflected in the well-known blue and white “H” sign—healing, health, hope.

Perspective on Health Insurance

Pennsylvania hospitals and health systems believe market competition in health insurance is important in achieving competitive premiums for employed groups and competitive payments to health care providers. This means that employers can make decisions regarding which health plans they offer their employees, health insurers can make determinations regarding which health care professionals and facilities they will include in their provider panel or network, and that health care professionals and facilities can make determinations regarding with which health insurance plans they'll contract.

Individuals in government-sponsored health insurance are able to choose among health plans and within a plan among providers. Any health plans serving Medicare, Medicaid, and the Children's Health Insurance Program must meet standards of provider network adequacy and must adhere to requirements to notify subscribers if there are any changes to the health plan or provider network that would impact the individual subscriber.

Individuals who have commercial health care coverage largely have such coverage through their employer as part of an employed group. Some individuals may purchase their health insurance directly from the insurer as an individual or family. In the case of employed groups, the employer makes the decision about what health plan to offer, and through its contract with the health plan makes other decisions, such as copayments (including differentials for use of out-of-network providers), drug formulary, benefit limitations, and other factors affecting an individual's use of health care services or financial implications of that use. Employed groups may enroll their employees in a commercial health insurance product or may self-insure and contract with a health insurer to serve as a third-party administrator.

The Pennsylvania Insurance Department regulates commercial health insurers that sell individual or family coverage and that sell to employers to cover their employees. Employers that self-insure and use third-party administrators are governed under federal statute (Employee Retirement Income Security Act, or ERISA), which are not subject to direct state oversight.

My testimony will focus on issues related to access to care for individuals that purchase health insurance directly and/or who are covered under an employed group that is not self-insured.

Issues Related to Access

Government Oversight—The committee has already heard from the Pennsylvania Department of Health regarding its role under Pennsylvania law regarding network adequacy and continuity of care.

The Pennsylvania Insurance Department also has an important role in assuring that subscribers to a health insurance policy receive the benefits which their policy entitles them to receive. As part of that responsibility the Insurance Department would prescribe the form and extent of any notice that a health insurer would have to use to advise its subscribers in the event of a major contractual change to its provider panel. I would note that the Pennsylvania Insurance

Department has posted a frequently asked questions document that provides information for consumers in the western part of the state given current market issues.

Understanding One's Health Insurance Coverage—It is important that individuals understand the provisions of their health plan, particularly as it relates to continuity of care (such as the change in a provider panel in the middle of an active treatment/health care, such as pregnancy or cancer) or as it relates to out-of-pocket and other factors if the individual chooses to use an out-of-network provider. Such other factors could include considering any procedures or hospitalizations ordered by an out-of-network health care professional as non-covered even though one might subsequently use a covered facility. These are just several examples of aspects of coverage that many consumers do not think about when making a coverage decision that could have implications for decisions should a plan not include their health care provider in their panel or in the event the provider chooses not to contract with their health plan. Questions about the interpretation of the benefits or other aspects of health insurance coverage should be directed to the customer service department of the respective health plan. While health care providers are familiar with the general practices of health plans, the particular terms of a subscriber agreement are more appropriately addressed to the health plan itself.

Transferring Care Documents—It is always important in changing health care providers to make sure that important medical history is provided to new health care providers. While health care providers are developing electronic health records, the use of such technology is not yet fully in place where a provider could access a patient's medical history solely through an electronic health record.

In the event that a health care provider is no longer contracting with a commercial health plan, there are issues that individuals should consider. First, while it is important to be prepared in the event that a provider is no longer in a health plan's panel, it is important to make sure that one knows exactly whether a change in a health plan's provider network is imminent or not. Employers may choose to offer multiple plans and that information would be provided to employees during their open enrollment period. Other health plan offerings may include the health care provider in question, and thus, the individual would then need to consider a variety of factors (access, quality, and cost) in choosing a benefit plan among the employer's offerings. Even if the employer only offers one health plan choice, it is always important for individuals to check on whether any substantive benefit and/or provider network changes have been made that would impact one's access to care.

The most important provider selection for most individuals is the selection of a primary care physician (i.e., family practitioner, pediatrician, internist, and in some cases, obstetrician/ gynecologist). A decision to change a practitioner is a personal decision that can take some time to find a practitioner that is geographically convenient and that is taking new patients; therefore, as soon as an individual knows that their provider is no longer in a health plan's panel they should begin that search. Once a decision is made, the individual can contact their former practitioner about transferring their medical records to the new practitioner. A phone call is the best way to find out from the practitioner how to make this request as the practitioner will need a

signed request and may require a reasonable amount of time to handle the request. There is no charge for medical records that are forwarded by a practitioner to another practitioner.

If an individual's health care includes specialists or sub-specialists that are no longer in a provider panel, a similar process for individual practitioners could be used. Again, a phone call can be made to determine how the transfer of records would proceed. In the case of changing a health care practitioner—whether primary or specialty care—individuals should make sure that their prescriptions are up to date and will cover the time period that they may need to wait to see their new practitioner.

If a health care facility or health care facilities are no longer included in a health plan's provider panel, an individual can make sure that any hospital or facility records regarding hospitalizations, surgeries, laboratory tests, and/or radiology tests (X-rays, MRIs, CT scans, etc.) are transferred. The transfer of such records from one hospital or facility to another is usually managed by a hospital's medical records department. One can reach the medical records department by calling a hospital's main number and requesting that department. Often times, this information can be found on a hospital's website. Again, there is no cost to an individual when these records and test results are transferred from one hospital to another. Hospitals and other health care facilities need a reasonable amount of time to fulfill these requests and encourage individuals to contact them as timely as possible to make sure the records are transferred to the facility in advance of anticipated surgery or other hospitalization.

Over my years in health care, Pennsylvania has had several health plans cease operations and there have been several hospitals that have closed. The types of issues I have outlined have been part of the state's oversight of the regulated insurer or health care facility to make sure that patient records are transferred appropriately at the behest of the individual. These transitions can be managed if properly considered by health plans, health providers, and regulators.

Summary

A vibrant insurance market, which offers an array of affordable health plans to Pennsylvania employers and consumers, supports access to quality health care for patients, and enables fair and appropriate payment practices for providers, is important. Individuals who receive health insurance coverage through commercial health plans need to trust the regulatory process to make sure that issues of importance to them—such as access to an adequate provider network and the ability to make sure important health information is available to one's health care providers—are addressed.

Again, HAP thanks you for the opportunity today for me to provide this perspective. I will be more than happy to answer any questions you might have.

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