Joan Joyce Carl CRNA MS
President
Pennsylvania Association of Nurse Anesthetists
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July 13, 2004

Peter J. Salvatore
Regulatory Coordinator
Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120

Re: Workers' Compensation Act—Provider Fees; Payment for Anesthesia Services

Dear Mr. Salvatore:

The Pennsylvania Association of Nurse Anesthetists would like to voice their support of the Insurance Department's Proposed Rulemaking on the Workers' Compensation Act—Provider Fees; Payment for Anesthesia Services. We are pleased that the Department agreed to review the Workers' Compensation conversion factor for reasonableness and ultimately decided to adjust the anesthesia conversion factor through issuance of a regulation.

Sincerely,
Joan J. Carl
Joan Joyce Carl CRNA MS

Original: 2409

Pennsylvania MEDICAL SOCIETY®

July 9, 2004

Peter J. Salvatore
Regulatory Coordinator
Insurance Department
1326 Strawberry Square
Harrisburg, Pennsylvania 17120

Re: Pennsylvania Bulletin: Workers' Compensation Act – Provider Fees; Payment for Anesthesia Services

Dear Mr. Salvatore:

I am writing as President of the Pennsylvania Medical Society in support of the above-captioned proposed rulemaking with respect to payment for Anesthesia Services under the Workers' Compensation Act.

Since the passage of the Workers' Compensation Act in 1993, with its establishment of a payment system for medical care services provided to injured workers based on the Medicare Resource Based Relative Value Scale (RBRVS), Anesthesiologists have received less reimbursement for anesthesia services compared to reimbursement from coordinated care insurers. This was due to the formula used by Medicare in calculating payment. This disparity has affected Anesthesiology increasingly with changes under Medicare to a point were workers' compensation payments are substantially below the rates of other payers throughout the Commonwealth. This disparity does not affect other specialties and generally the rates paid under Workers' Compensation for their services exceed payments received from other payers.

The Pennsylvania Society of Anesthesiologists (PSA) initiated the process provided for under the Workers' Compensation Act permitting the Insurance Commissioner to review the adequacy of payment for medical services and treatment. The Medical Society has assisted and supported PSA's efforts to provide documentation of the payment disparity sufficient to satisfy the Commissioner's review.

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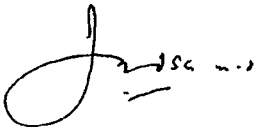
The Society believes that PSA has well documented the reduced payment levels and the need for this proposed increase in payment allowance.

The Pennsylvania Medical Society appreciates the opportunity to comment in support of this proposed rulemaking.

Sincerely,



Jitendra M. Desai, M.D.
President

Cc: Senator Gibson Armstrong, Chair, Senate Banking and Insurance Committee
Senator Jack Wagner, Minority Chair, Senate Banking and Insurance Committee
Representative Nicholas Micozzie, Chair, House Insurance Committee
Representative Anthony DeLuca, Minority Chair, House Insurance Committee
John R. McGinley, Jr., Chair, Independent Regulatory Review Commission
Carol E. Rose, M.D., President, Pennsylvania Society of Anesthesiologists

Original: 2409

Comments on the regulation listed below have been received from the following:

Reg #	*Regulation Title*
11-222	*Workers' Compensation Act-Provider Fees*

Mr. Samuel R. Marshall
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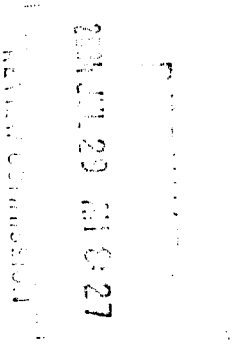
Date Received *07/26/2004* Date Sent To Cmtes/IRRC *07/26/2004*



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Samuel R. Marshall
President & CEO

July 26, 2004

Peter J. Salvatore
Regulatory Coordinator
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120

Re: Proposed rulemaking - payment for anesthesia services

Dear Mr. Salvatore:

The Insurance Federation, on behalf of our members and in conjunction with our national trade association counterparts, submits the following comments in opposition to the Insurance Department's proposed Chapter 167.

The Department proposes to increase by regulation the reimbursement of anesthesiology expenses covered under the Workers Compensation Act. While the Department concludes (without any analysis) this would have minimal overall financial impact, it concedes this is a 63% increase in reimbursement of these expenses.

The Department justifies its proposed increase by concluding - based solely on data submitted by the Pennsylvania Society of Anesthesiologists (PSA) - that reimbursements for these expenses under the Act are substantially below the rates paid by managed care payors in Pennsylvania, and that this "substantial disparity" does not exist with "other (un-specified) specialties" (indeed, the Department notes that many other providers get substantially more under the Act than they do from managed care payors).

The Department presumably uses these conclusions to "determine" that the Act's payment level for anesthesia expenses is not reasonable, and that its proposed 63% increase establishes a reasonable payment level.

We emphasize that this is only presumed - because while the Department explains in the Purpose Section of the proposed regulation that the Act allows the Commissioner to set a new reimbursement rate if she determines that the existing one is not reasonable, the Department never states such a determination.

That goes to our overriding objections to the regulation: The Department has failed to make the findings required under Section 306(f.1)(3)(i) and (v) of the Act to justify its proposed 63% increase, and it has arrived at an increase with no apparent concern of the Act's goal in establishing a fee schedule - medical cost containment.

1. The Department has neither made nor supported a determination that the current reimbursement levels are unreasonable.

The Department never determines, as required by Section 306(f.1)(3)(i) of the Act, that the allowance now paid for anesthesia services is unreasonable. This isn't mere semantics or a parsing of the proposed regulation - although the Department's failure to clearly state such a determination in its proposed rulemaking, even after acknowledging it is required by the Act, is telling.

It goes to the failure of this proposal: The Department not only does not frame its conclusions in terms of unreasonable reimbursement levels, as required by the Act, it never even suggests it analyzed those levels for unreasonableness, or sets forth the criteria it used for considering what might be unreasonable levels.

The Department apparently considered only data from the PSA concluding that its members are getting less under the Act

Although not stated in the regulation, the Department apparently accepted this data without question, public scrutiny or looking at other possible sources. Even in the regulation, the Department notes the data is to be kept confidential, although it assures that the PSA will supply an aggregate summary on request - hardly the thorough and public review that should go with a 63% increase.

In essence, the Department has apparently concluded that whether the Act's reimbursement level is unreasonable can be established solely by a comparison of that reimbursement level with reimbursement levels from managed care plans selected by the provider group requesting an increase.

Nothing in the Act or current regulations suggests this is the proper standard. While it might be part of a standard of unreasonableness, so should other, more compelling considerations - considerations apparently ignored, or at least not mentioned, by the Department in its presumed finding of unreasonableness. Among the logical considerations:

- Has the reimbursement level under the Act resulted in (or even threatened to result in) a lack of available and qualified care for injured workers? That should be the overriding question in determining whether a payment level is unreasonable - and yet it isn't even considered in this proposal.

- How does the reimbursement level under the Act compare with levels paid by all other payors, not just HMOs and PPOs selected by the PSA? For instance, how does this level compare with what anesthesiologists are being paid under Medicare, Medicaid and auto insurance? Tellingly, the Department (and the PSA) concedes that at least one Medicaid HMO pays less than the current level in the Act. Does that mean the Department is determining that the Commonwealth's Medicaid program is paying unreasonable rates? The PSA might say that; the question is whether the Department is.

- To the extent a comparison of the Act's reimbursement level with that of various managed care entities is germane (again, we believe it should not be the controlling or exclusive comparison), the Department should at least consider other factors that are part of any reimbursement program in managed care - as with fees set, in part, on the provider's willingness to accept conditions and restrictions not present or required under the Workers Compensation Act.

The Department also gives considerable weight to its conclusion that some other specialties get more under the Act than they do from managed care entities (presumably only those selected by the PSA), while that disparity is reversed for anesthesiologists. We question the conclusion: The Department never explains the specialties examined, or the level of disparity, or the data used.

But even assuming different disparities, we question whether that justifies the determination that the reimbursement level under the Act for anesthesiologists is the unreasonable one. It could be that the managed care entities selected by the PSA are making unreasonable payments to its members - unreasonably high.

Of course, if the Department is concluding that payment levels by managed care entities are the standard of reasonableness, it then must also conclude that the Act is paying unreasonably high amounts to all providers where the disparity favors them. If that is the case, we would ask that the Department revise this proposal to address all provider groups where it found unreasonable payment levels under the Act - not just those it believes are too low, but also those it believes are too high.

Further, even if the Department is given every benefit as to its missing inferences and presumptions, its "determination" is hardly a fair one. It came after looking only at PSA data, without an opportunity for meaningful public comment, scrutiny or review, or the chance for questioning the PSA. That is hardly the stuff

The Department notes it received pre-exposure comments from the Federation. True enough, and we raised many of the same concerns outlined in this letter - but only at the very end, after the Department had already made its "determination," and without any response or explanation from the Department. As a general rule, agency determinations are usually made based on a record that allows meaningful input and interchange from all affected parties before conclusions are reached. That did not happen here, a fatal flaw in the Department's so-called "determination."

Section 306(f.1)(3)(i) of the Act expressly states that the Commissioner must first determine a payment level to be unreasonable before setting a new level. The Department has failed to do so in this regulation. Indeed, it never sets forth the criteria by which it considers a payment level to be unreasonable - and it has ignored some pretty logical ones as listed above. For that reason alone, the proposed regulation should be rejected as premature at best.

2. The Department's proposed reimbursement level is unreasonable and contrary to the goals of the Act.

Having "determined" the Act's reimbursement level for anesthesiologists is unreasonable (albeit with the shortcomings noted above), the Department's proposed regulation goes on to determine that a 63% increase should be the new level. Again, it offers no explanation of its reasoning - although the inference is that this is appropriate because it approximates what the PSA claims selected managed care entities are paying its members.

We believe the proposed reimbursement level is the one that is unreasonable, and is contrary to the Act's goal of medical cost containment in workers compensation. Even if one assumes the anesthesia reimbursement levels under the Act are unreasonably low, the Department offers no justification for its 63% increase as the best, most

As noted in the preceding section, different payors pay different levels for anesthesiology services. The Department has looked at one group of payors - managed care plans selected by the PSA - and decided their payment levels are the most reasonable. But it should at least have looked at other payors, and considered the broader factors noted in the preceding section, in reaching this conclusion.

That is particularly true given that the Act's purpose in this area is to control medical costs. Indeed, the principle regulation in this area is Chapter 127 - titled "Workers' Compensation Medical Cost Containment."

The Department, however, does not appear to have considered other, presumably lower payors for anesthesiology services - as with Medicare, Medicaid and auto insurers - in coming up with its proposed reimbursement level. It looked only at the (apparently) highest payment source and took an average from it. We understand there can be a range of what might be a reasonable level of payment - but to be consistent with the Act and its goal of medical cost containment, the Department should have considered alternatives other than the highest end.

3. The Department's reliance on Section 306(f.1)(3)(v) of the Act is misplaced.

The Department justifies much of this proposed regulation by claiming the PSA has fulfilled the requisites of Section 306(f.1)(3)(v) of the Act. We don't believe those requisites have been met; further, even if they have, they do not justify a determination that the Act's reimbursement levels for anesthesia services are unreasonable and that a 63% increase is the best level of reasonableness.

Section 306(f.1)(3)(v) provides that the Commissioner must review a provider's reimbursement level for reasonableness under the Act if she determines that the level is more than 10% lower than the provider receives from coordinated care insurers, including ones that are HMOs or PPOs.

This seems pretty straight-forward and pretty limited, but that isn't how the Department has applied it.

The first question to be answered under this subsection is what "coordinated care insurers" - correctly labeled as CCOs by the Department in this regulation - are paying. CCOs are defined under the Act as organizations licensed in Pennsylvania and certified by the Secretary of Labor and Industry for providing services to injured workers. While CCOs may include HMOs and PPOs, they are different: "Coordinated care" is a term unique to the Act and workers compensation, and the organization providing it - whether an HMO, PPO or some other entity - must also be certified by the Secretary as covering and caring for injured workers.

The Department never mentions what CCOs it studied; none are mentioned in the four PSA reports it references, either. The Department seems to assume that HMOs and PPOs, even if not dealing with injured workers, nonetheless can be included as CCOs.

That misreads the Act. An HMO or PPO is not a CCO or coordinated care insurer under Section 306(f.1)(3)(v) unless it has also been certified as such by the Secretary. So the Department should not be persuaded or obligated by reimbursement levels of HMOs or PPOs that are not also CCOs - and at least based on the documentation in the regulation, none of the managed care entities it examined are CCOs.

This is not just semantics or hair-splitting. It is understandable that the Act requires the Commissioner to examine the reasonableness of a workers compensation fee schedule reimbursement level if insurers and providers, through CCOs, are agreeing to significantly higher levels in workers compensation on their own. But it is not so understandable if the comparison goes to what insurers in entirely different lines of coverage - as with HMOs and PPOs in traditional health insurance - are paying. The former comparison is an apples-to-apples approach. The latter is apples-to-oranges - still fruit, perhaps, but not the same.

Therefore, unless the Department can point to CCOs - those certified by the Secretary of Labor and Industry, not just HMOs and PPOs - as part of its study, any reliance on Section 306(f.1)(3)(v) is misplaced.

Further, the Department suggests in its regulation that any disparity between the Act's reimbursement level and that of CCOs not only mandates a review of the Act's reasonableness, but also demands a conclusion that the Act is unreasonable and the CCOs are reasonable. The former is true - remembering the disparity must be with CCOs, not managed care entities generally. The latter, however, is not.

A call to investigate is different than a presumption of what the investigation should prove. Nothing in section 306(f.1)(3)(v) suggests that a disparity between the Act's reimbursement levels and those of CCOs requires a finding of unreasonableness. The Department's proposed regulation, however, rests on that suggestion and should therefore be rejected.

4. The Department's proposed regulation fails to comply with the requirements of the Regulatory Review Act.

The Regulatory Review Act requires that, "first and foremost," an agency has the statutory authority to promulgate the proposed regulation, and that the regulation conforms to the intention of the General Assembly in the enactment of the underlying statute.

The proposed regulation falls short on both accounts. While the Act gives the Commissioner the authority to change its fee schedule, it sets preconditions on it - namely, the preconditions that the fee schedule be determined to be unreasonable and that any new reimbursement level be reasonable.

As outlined in the preceding sections, this regulation lacks any analysis, much less determination, of the unreasonableness of the fee schedule and the reasonableness

of the 63% increase as to anesthesiology services; it has only the PSA's misdirected reliance on the reimbursement levels of selected managed care plans (not CCOs). Absent a meaningful analysis and determination of unreasonableness, however, the Department is without the statutory authority to promulgate this regulation.

The regulation also falls short in fulfilling the intention of the Act in proposing a 63% increase in the reimbursement level for anesthesiology. The Act intends to control medical costs; whatever else a 63% increase does, controlling costs is not one. Granted, the Act is not meant to control costs at the expense of providing available and qualified treatment for injured workers. But that is not a consideration even mentioned by the Department in the proposed regulation.

For all of the foregoing reasons, we recommend the proposed regulation be rejected. The public interest in the Act requires an ongoing focus on meaningful medical cost containment for all providers being reimbursed under it. The proposed regulation goes in the opposite direction, allowing a massive increase for anesthesiology services without any consideration of whether it is needed to ensure both quality treatment of injured workers and cost containment for those paying for workers compensation coverage.

Thank you for the opportunity to comment on this. Attached are our earlier letters to the Department referenced in the proposed regulation; their arguments are part of our objections to this regulation.

Sincerely,

Samuel R. Marshall

C: Honorable Joseph B. Scarnati, III
Chairman, Senate Labor and Industry Committee

Honorable Christine M. Tartaglione
Democrat Chairman, Senate Labor and Industry Committee

Honorable Robert Allen
Chairman, House Labor Relations Committee

Honorable Robert E. Belfonti, Jr.
Democrat Chairman, House Labor Relations Committee

Robert E. Nyce
Executive Director
Independent Regulatory Review Commission