PFC
PHYSICIANS FOR FAIR COVERAGE
PHYSICIANS PARTNERING WITH PATIENTS

August 30, 2019

The Honorable Frank Pallone, Jr.
United States House of Representatives
2107 Rayburn Office Building
Washington, DC 20515

Dear Chairman Pallone:

Thank you for the opportunity to appear before the Energy and Commerce Subcommittee on Health on June 12, 2019 at the hearing entitled "No More Surprises: Protecting Patients from Surprise Medical Bills." It was an honor to speak on behalf of the tens of thousands of physicians who are members of Physicians for Fair Coverage (PFC), a non-profit, non-partisan, multi-specialty association partnered with patient advocacy groups.

I and my fellow physicians of PFC are strongly dedicated to putting the patient first and ending surprise medical billing. We continue to applaud your effort to protect patients from the surprise insurance gaps in unanticipated out-of-network care, and collectively are committed to finding a federal solution that not only creates strong financial protections for our patients, but also ensures their access to care, especially in an emergency, and improves transparency of pricing and network adequacy.

In response to your letter of August 12, 2019, I am respectfully submitting the following document addressing the additional questions for me from certain members of the Committee.

We appreciate your leadership on this important issue and, again, thank you for the opportunity to comment. PFC stands ready to work with you in the best interest of our patients and the physicians who care for them. If you have any questions or need additional information, please do not hesitate to contact our President and CEO, Michele Kimball, at 651-955-8878 or mkimball@pfc-assn.org.

Sincerely,

Sherif Zaafran, MD, FASA
Chair, Board of Directors

Cc: Hon. Greg Walden, Ranking Member, Committee on Energy and Commerce
Hon. Anna G. Eschoo, Chairwoman, Subcommittee on Health
Hon. Michael C. Burgess, Ranking Member, Subcommittee on Health

Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"No More Surprises: Protecting Patients from Surprise Medical Bills"
June 12, 2019

Sherif Zaafran, MD

The Honorable Michael C. Burgess, M.D.

1. Dr. Zaafran, you mention in your testimony that under a benchmark approach for out-of-network care, "health plans would be greatly incentivized to not renew contracts with practices with existing contracts above the median in-network rate." Have there been any states that have implemented policies that have resulted in declining physician reimbursement?

Thank you, Representative Burgess. Yes, we have seen these concerns realized in California where a benchmark-only approach is being used. The California Medical Association has reported providers are increasingly faced with cancelled contracts and insurance companies are offering dramatically under-market rates for contract renewals, all in an effort to take advantage of a low default one-size-fits-all benchmark approach. Additionally, a recent article in the American Journal of Managed Care provides further evidence the benchmark-only approach in California has shifted negotiating power to insurers, giving them undue leverage during in-network contract discussions. To be certain, dramatic reductions in physician reimbursement imperil our ability to offer economically-viable care, attract and retain high quality physicians to emergency medicine, and ensure we have these physicians available 24/7, every day of the year, including nights, weekends, and holidays.

The Honorable Gus M. Bilirakis

1. How do we reverse perverse incentives to allow more providers to be in-network and care for more patients, which is obviously in their interest to do?

Thank you for this question, Representative Bilirakis. To effectively end surprise billing, we should ensure any solution does not harm the vast portion of the market currently functioning well, one which has brought many providers in-network. As we work to find solutions to encourage even more providers to join networks and insurers to negotiate fairly, we should be sure we are furthering successful market dynamics that result in a level playing field for these negotiations. Ensuring a fair payment standard for unanticipated out-of-network care through an Independent Dispute Resolution process will help establish a basis for providers and payers to work out payment agreements in the future. Ultimately, at some point, most physicians will see out-of-network patients due to Americans traveling for work or vacation, so it is crucial a process exists to resolve impasses over payment in a way that is fair to both physicians and payers, and keeps patients completely out of the middle.

2. One criticism of a benchmark to median rates is that all the contracts above that rate could immediately be brought out-of-network, further lowering the median rate. What long-term effect could this have on access to care, as physicians would be unable to negotiate any rate above the median in their geographic area?

A benchmark-only rate, without the ability to be appealed, could have an incredibly detrimental long-term effect on access to care. A benchmark-only rate could be easily manipulated by insurance companies to drive down in-network reimbursement to unsustainable rates. Physicians at risk of being pushed out-of-network would be forced to accept low default one-size-fits-all rates, regardless of the quality of the care they provide or the complexity of the care. A benchmark rate pays all providers as if they are exactly the same, ignoring the quality initiatives of the physician by underpaying high quality physicians who help reduce avoidable costs such as hospital readmissions, and overpaying those physicians who are not prioritizing quality improvement. Not only would quality suffer, but benchmark rates would make it difficult to provide economically-viable care, leading to staffing shortages, longer wait times, and potentially to facility consolidations and closures. Small, rural, and underserved communities would be hit hardest, as suburban and more populous urban areas could have higher benchmark rates. Furthermore, small and rural hospitals do not have the financial ability to make up for commercial reimbursement cuts from artificial and inadequate benchmark rates given their disproportionately higher rates of uninsured and underfunded Medicaid reimbursement levels compared to other providers.

3. One criticism of the Ruiz-Roe proposal is that it directs the arbiter to look at an independent database of physician charges when deciding which offer is more reasonable. Critics contend that this could allow physicians to raise charges, but a study by Georgetown indicates that physician charges in New York have actually gone down 13% since their law went into effect. Why might that be the case? Could it be because both physicians and insurers are incentivized to be reasonable and come to the table before arbitration?

I believe a key component of the New York model is that it pushes both sides to be reasonable and negotiate a fair reimbursement rate before they even get to arbitration. This is the main reason why other states, including my home state of Texas, are adopting the same model for ending surprise billing. With an Independent Dispute Resolution process, both sides know if they are not reasonable with their offer they will surely lose in this process. As a result, both sides have strong incentives to come to the table with fair offers to have the greatest chance of success. In Texas, for example, our model ensures the stability of the existing market by using previously contracted rates as a key metric in the process. This minimizes disruption in the already contracted market and helps address concerns about increasing costs. Furthermore, as data from New York's experience has shown, once the process has been in place for a few years, it begins to reach a state of equilibrium where neither side is always winning or always losing, a truly optimal outcome.