



**Testimony of Sherif Zaafran, MD, FASA
Chair, Physicians for Fair Coverage
Before the
House Committee on Energy and Commerce
Subcommittee on Health**

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Chairwoman Eshoo, Ranking Member Burgess, and distinguished Members of the Committee, thank you for inviting me to testify on behalf of Physicians for Fair Coverage (PFC). I serve as Chairman of the Board of PFC. I also serve as the President of the Texas Medical Board, and the National Legislative Liaison for US Anesthesia Partners (USAP) and continue to treat patients as a practicing anesthesiologist. While I wear many hats, today I am providing testimony through my role as Chairman of PFC.

PFC is a non-profit, non-partisan, multi-specialty association of tens of thousands of physicians partnered with patient advocacy groups. PFC members care for more than 50 million patients each year in more than 3,000 facilities nationwide. We are committed to finding a solution to surprise medical bills that creates strong patient protections, ensures access to care, and improves transparency. PFC-affiliated physicians prefer to be in-network and are actually in-network with 95 to 99 percent of the patients they see. The data indicates that these numbers are representative of the larger market for emergency medicine, anesthesiology, and radiology and that the vast majority of these doctors are in-network.¹ We would also remind the Committee that hospital-based physicians treat a significantly higher portion of uninsured, Medicaid, and Medicare patients than most other practices. We treat all patients who need care at our facilities, without regard to their insurance status or their ability to pay.

On behalf of PFC, I want to commend all of you, as well as the Chairman and Ranking Member of the full Energy and Commerce Committee, for working to address out-of-network surprise billing for our patients. As a physician, I live and work by the creed “do no harm.” I believe that any solution to surprise billing should meet this test as well. PFC supports the intent of the Committee’s draft legislation, as we strongly believe patients should be protected from the potential financial stress associated with unanticipated out-of-network care.

We believe protecting patients by eliminating balance billing and ensuring patients pay no more than their in-network cost-sharing is the right thing to do. We also support many of the transparency requirements that work towards ensuring no patient is surprised with an out-of-network provider as part of scheduled care.

¹ https://www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf; <https://hcupnet.ahrq.gov/#setup>
<https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing>; <https://www.ama-assn.org/sites/amaassn.org/files/corp/media-browser/public/health-policy/PRP-2017-physician-benchmark-survey-patient-mix.pdf>.

However, federal intervention to protect patients also requires careful federal intervention to deal with the dispute that arises between the plan and physician over reimbursement as a result of eliminating the ability of the physicians to bill for their services.

PFC believes the federal intervention to resolve this dispute should comport with the following principles: 1) ensure fair reimbursement for specific physicians case-by-case, who end up providing services to patients who are out-of-network; 2) protect the vast majority of the in-network contracted marketplace so that the solution doesn't incentivize and generate a greater volume of out-of-network claims; and 3) create an incentive for currently out-of-network plans and physicians to go in-network. PFC is concerned that the "median in-network" benchmark currently in the Energy and Commerce discussion draft falls short of these principles and could potentially drive more patients out-of-network.

The median in-network benchmark will not represent fair reimbursement for specific physicians case-by-case who end up providing services to patients who are out-of-network. There are significant differences from one patient encounter to another such as training and experience of the physician, circumstances and complexity of the episode, the cost intensity of the location, and the quality of the care provided. The median in-network rate doesn't recognize any of these differences and would reimburse based on an artificial formula set in statute that simply can't reflect the tremendous diversity of reimbursement rates needed to sustain a complex, dynamic market.

However, perhaps the greatest concern is the negative effect that a benchmark approach for out-of-network care would have on the contracted marketplace throughout the country (which represents the vast majority of patient volume). Under this formula, half the in-network rates in a given area would be above this number and half would be below by definition. Health plans would be greatly incentivized to NOT renew contracts with practices with existing contracts above the median in-network rate. Doing so would immediately reduce their expenditures and would also drive down the median in-network rate over time, leading to a vicious cycle of jamming down physician reimbursement to unsustainable levels. Ultimately, this would harm patients by creating an unsustainable economic environment, especially for physician practices that treat over 200 million patients a year. The public health risks are substantial and foreseeable if a policy is implemented that would erode access to and quality of care for patients.

Our recommendation for revising the draft to meet the principles laid out above is to turn the benchmark payment concept into an interim payment with the ability of either side to go to a baseball-style Independent Dispute Resolution (IDR) process for recourse if the payment is inappropriate.

The interim payment should be higher than the median in-network rate in order to mitigate the volume of disputes going to IDR and should be set in a way that doesn't allow health plans to manipulate it by canceling contracts with the highest reimbursement. We believe that the interim payment will resolve most disputes; for those that it does not, IDR provides the opportunity to appeal the payment in a fair way. And this cuts both ways – plans and providers alike will have the opportunity to appeal.

PFC has been very involved in the debates on this issue in the states and we note that solutions incorporating IDR have proven successful. Twelve states have now adopted a solution incorporating baseball-style IDR including Washington state, Nevada, and Colorado this year and most recently my home state of Texas.²

² Reflects data reported by the Commonwealth Fund and recently enacted bills in Colorado, Nevada, and Washington. <https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing>.

Each state sets their model up a bit differently, but they all have the same basic framework in common—the patient is protected; both parties have recourse to a neutral third-party in the out-of-network payment dispute if they believe the other party is unreasonable; each party is incentivized to provide their most reasonable offer; and the parties are incentivized to remain or go in-network and avoid the dispute resolution process.

Perhaps what is most telling about these four state efforts this year is that the key stakeholders—providers, insurers, and patient groups—all supported that framework which then passed with bipartisan support in their state legislatures. We believe a federal solution should build on this success by incorporating these key features for resolving payment issues between providers and payers. We encourage the Committee to include this IDR process in future iterations of the legislation.

The inclusion of an IDR process is a critical aspect of a solution that will preserve existing in-network arrangements, ensure both providers and payers have the ability to achieve a fair rate, take the patient out of the middle, and avoid significant disruption that would result from moving the market to a set benchmark rate. A poorly constructed solution could threaten patients' access to care and providers' ability to serve their communities.

Economic Realities Hospital-Based Physicians Face

The overwhelming majority of PFC-affiliated physicians are hospital-based physicians that provide around-the-clock care every day of the year, regardless of a patient's coverage status. The provision of these services ensures that patients with a middle-of-the-night heart attack or emergency C-section can seek and receive immediate care from qualified professionals.

Hospital-based physicians face a fundamentally different set of economic realities than other specialties who provide primarily scheduled care. Unlike physicians who have the ability to select whether they will see a patient based on their health insurance coverage, hospital-based physicians have no control over payer mix or plan type. This is because efficient, consistent care typically requires an emergency medicine, radiology, anesthesiology, or pathology group to cover all the patients at a given facility. Further constraints are already embedded in federal law, as the Emergency Medical Treatment and Labor Act (EMTALA) requires physicians to provide emergency care regardless of a patient's ability to pay.

The payer with the highest percentage of patients with an emergency department visit is Medicaid (32 percent), followed by private insurance (31 percent), Medicare (23 percent), and the uninsured (14 percent).³ Thus, 46 percent of the patients seen by emergency medicine physicians are uninsured or Medicaid patients. Compare this to orthopedic surgery which has just 6 percent of uninsured and Medicaid patients.⁴ Moreover, commercial rates cannot be discussed in a vacuum. They must be viewed in the context of the overall economic reality of the practice. After taking all these types of payers into account, the weighted average reimbursement per patient is about \$155 per visit, or just 107 percent of Medicare.⁵

³ *Ibid.*

⁴ <https://hcupnet.ahrq.gov/#setup>; <https://www.beckersasc.com/asc-turnarounds-ideas-to-improve-performance/payer-mix-at-orthopedics-driven-ascs-6-statistics.html>; <https://www.ama-assn.org/sites/ama-assn.org/files/corp/mediabrowser/public/health-policy/PRP-2017-physician-benchmark-survey-patient-mix.pdf>.

⁵ <https://hcupnet.ahrq.gov/#setup>; www.cms.gov/apps/physician-fee-schedule/search; Truven Payer Claims Database; https://www.aap.org/en-us/professionalresources/Research/Medicaid%20Reimbursement%20Reports/medicaid_reports_national_all.pdf; Medicare PUF file.

If new policies go into effect that jam down commercial rates for emergency medicine, the economics of the practice will become untenable with virtually half their patients paying nothing or significantly underpaying relative to the cost of care. EMTALA rightfully eliminates the ability of hospital-based physicians (which includes not just emergency physicians, but also radiologists, surgeons, and anesthesiologists) to turn away patients, but this inherently means physicians have no ability to adjust their patient-payer mix, and with Medicaid and Medicare only reimbursing through artificially low set rates, providers cannot negotiate higher rates there to make up the difference.

It is also worth considering hospital-based physician fees in the overall context of health care costs. Despite statements to the contrary, hospital-based physician professional fees are not large enough to drive overall health care cost inflation. Combined emergency department, anesthesiology, and radiology professional fees are 2.3 percent of the total private insurance spending per beneficiary.⁶ So if the policy goal is to drive down health care costs, driving down physician fees will have very little impact—particularly when you consider that such an impact would destabilize the EMTALA-based emergency care safety net in this country. Frankly, my emergency medicine colleagues should be celebrated for providing high quality care under inherently unpredictable circumstances to 140 million patients a year for only \$155 a visit, not vilified based on highly selective, misleading data as we’ve recently seen published as part of this policy debate.

Concerns with Median In-Network Rate As Benchmark

PFC believes it is equally important to not only protect patients from unexpected out-of-pocket costs, but also to ensure they have access to care where and when they need it. As highlighted above, we have serious concerns that setting payment at the median contracted rate for services in the same geographic area will threaten access to care. Basing the reimbursement mechanism on the median contracted rate is challenging and subject to insurer manipulation. This lacks transparency and visibility in what is regarded by insurers as highly-protected, confidential, and guarded information. The median contracted rate is not a viable standard that ensures transparency and market standards.

Additionally, a single payment standard doesn’t allow for differentiation in the marketplace based on value, quality or complexity and cost intensity of the practice location. In particular, the inability to be compensated for the types of quality metrics that ultimately decrease the overall cost of care will inhibit providers who invest to create this value and drive everyone to an inefficient “one-size-fits-all” reimbursement standard.

To be clear, PFC physicians prefer to be in network because it means higher patient volume, greater referrals, lower administrative costs, fewer denials, and guaranteed payment including assurances of direct pay through assignment of benefits. To secure optimal, market-based, in-network rates requires physicians and insurers to negotiate reimbursement on equal footing and under arms-length transactional settings; optimal negotiations implies concessions will generally be made on both sides. The contracted in-network rate is a heavily discounted one that physicians accept in return for these considerations which are not available to out-of-network physicians.

⁶ Determined using data from: <https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-09-healthinsurance.pdf>; <https://www.healthcostinstitute.org/research/annual-reports/entry/2017-health-care-cost-and-utilization-report>; Truven payer claims database; <https://www.prweb.com/releases/2011/2/prweb8127064.htm>; Truven payer claims database; <https://hcupnet.ahrq.gov/#setup>; https://www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf <http://monitor.pubs.asahq.org/article.aspx?articleid=2705479>; <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb223-Ambulatory-Inpatient-Surgeries-2014.jsp>; <https://www.ama-assn.org/sites/ama-assn.org/files/corp/mediabrowser/public/health-policy/PRP-2017-physician-benchmark-survey-patient-mix.pdf>.

The current benchmark in the draft bill will remove incentives for insurers to negotiate in good faith during contract negotiations. By using the median contracted rate as a payment standard, we contend that health plans may simply cancel contracts, refuse to negotiate rates that are above the median, or drive rates down over time to lower the median. Insurers will have an incentive to lower contracted rates because all care will be subject to the payment standard and there will be no ability for non-contracted providers to charge more than contracted rates.

Physicians have already experienced this type of behavior by health plans in states such as California which took a similar approach to the committee's discussion draft. California's 2016 surprise billing law uses the weighted average of in-network rates. **The experience in California shows that this benchmark approach does not work.** The law has resulted in insurers refusing to renew long-standing contracts or offering significantly reduced rates that undermine good faith contracts. Insurers in the state have little incentive to contract with physicians. Some physician groups are reporting that their insurers are seeking unreasonable and unjustified payment reductions of 21-40 percent.

In fact, since insurers often pay a smaller percentage of the allowed amount for out-of-network services, the insurance companies are further incentivized to cease contracting efforts or refrain from negotiating or renegotiating contracts where network adequacy standards are lacking. At a time when there are already physician shortages in many rural and economically disadvantaged communities, setting payments at unsustainable levels will ultimately exacerbate the current predicament and harm access to care.

Recommended Framework: Interim Payment With IDR

PFC supports proposals that would establish a process that both protects patients and preserves the broader market which is largely functioning. As discussed, we believe the correct framework to accomplish this goal is one that 1) eliminates balance billing; 2) sets a reasonable interim payment for out-of-network payments; and 3) provides recourse to either party through an IDR process if they believe the other party is not being reasonable.

PFC supports the concept of an appropriate benchmark as part of an Interim Direct Reimbursement payment as long as it is reasonable and coupled with a process for physicians to appeal that rate. An additional dispute resolution process would ensure a level playing field and that neither side would gain an unfair edge during contract negotiations. Additionally, setting an appropriate interim payment would also reduce the number of claims that go to the dispute resolution process. Such a process would ensure that incidental claims are paid with minimal increased cost to the system and the parties involved.

PFC recommends the process include several guardrails around the dispute resolution process that would ensure the arbiter has a clear picture of the factors involved in determining a fair and appropriate payment. These factors should include:

- the previously contracted rate and contracting history between the plan and provider under dispute. This provision is particularly important to maintaining a balanced environment and ensuring that the contracted market remains stable, which benefits everyone: patients, insurers, self-insured employers, physicians and hospitals;
- the physician's level of training, education, experience, specialization, the acuity level of the patients, and physician quality and outcome metrics;
- past compliance with contract terms;

- the circumstances and complexity of the case; and
- other relevant economic aspects of physician payment for that specialty in the same geographic area.

PFC believes these parameters would ensure the process has a stabilizing effect on insurance networks.

It is important to emphasize that we expect such an IDR model to be used relatively rarely. The purpose of the IDR is to provide fair recourse to either the plan or provider if the other party is being unreasonable. Thus, it is important as a backstop, but in practice it will be rarely used because each party will now be incentivized to be reasonable in their private negotiating. They will know that they will lose if they are unreasonable and the other party initiates the dispute resolution process.

Indeed, as we saw in New York, the out-of-network rate dropped 68 percent from 20.1 percent to 6.4 percent after their IDR solution was put in place. This suggests that the plans and providers in that state found it more beneficial to negotiate an in-network contract than to fight out-of-network reimbursement through arbitration.

State Experience

PFC’s support for an independent dispute resolution process is largely based on our work in the states. We looked to the success of the bipartisan model used in New York State. That model is both effective and has the support of consumer and patient groups.⁷

According to a recent case study by researchers at the Georgetown University Center on Health Insurance Reforms,⁸ the independent dispute resolution process has resulted in a decrease in out-of-network claims, a “dramatic” decline in consumer complaints about surprise bills, and no “indication of an inflationary effect in insurers’ annual premium rate filings.” The law has also led to stronger protections for patients and more patient-centric health plans; enhanced transparency from health insurers; increased network participation; and fewer out-of-network claims.

Other states—from Colorado and Nevada to Texas and Washington—have recently passed legislation based on a dispute resolution process. For example, Washington Governor Jay Inslee recently signed legislation into law that would protect patients by paying out-of-network providers a “commercially reasonable” amount based on payments for the same or similar service in the same geographic area. There is then a binding arbitration process for when an insurer and provider cannot agree on a price for the covered service.⁹

Also, the Texas Legislature has approved legislation (SB 1264) that prohibits surprise billing; establishes an initial payment of the usual and customary rate, the agreed amount, or the amount from the appeals process; and sets up an arbitration process to resolve payment disputes. These two examples are from states that have been examining and working toward addressing the issue of out-of-network billing for years.

⁷ https://advocacy.consumerreports.org/wp-content/uploads/2014/07/NY.OON_Case_Study.pdf.

⁸ Georgetown University Health Policy Institute Centers on Health Insurance Reforms, New York’s 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study, May 2019; <https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9>.

⁹ Washington HB 1065. <https://app.leg.wa.gov/billsummary?BillNumber=1065&Year=2019&Initiative=false>.

The trend of states legislating an interim payment coupled with a dispute resolution process is not something that Congress should overlook. The fact that key stakeholders in those states—patient groups, providers, insurers—all agreed on this framework is critical to ensuring a bill can ultimately be passed. In total 12 states have a dispute resolution process that has been approved by their legislature or has been implemented.¹⁰

While we support these state efforts, PFC believes that state protections should not apply unless they meet the minimum federal standard. Federal patient protections and independent dispute resolution standards for physicians must set a floor in order to protect access to the safety net in all 50 states. State approaches should only apply if they provide even greater patient and physician protections. Moreover, physicians should have sufficient and adequate access to the IDR process under applicable state provisions and, if they do not, they should have access via the federal IDR process.

All Payer Claims Databases

PFC believes it is imperative that a verified, statistically representative benchmarking database independent from both providers and payers be utilized when determining rates. The PFC proposal specifies that the Interim Direct Reimbursement be determined using a benchmarking database maintained by a nonprofit organization that is not affiliated with or receives funding from a health insurance company.

While the draft bill leaves the methodology to the rulemaking process, it does include grant money for states to establish or maintain All Payer Claims Databases (APCD). We have concerns about relying on individual state APCDs to determine rates. There will be a significant lag time for states to pass legislation authorizing the collection of claims, apply for federal grant money, and build the infrastructure. It is also very expensive to establish and maintain.

PFC would ask you to use FAIR Health, which is a non-profit, independent, national data repository established to bring clarity to health care costs and health insurance information. The database includes more than 28 billion privately billed medical and dental procedures covering more than 150 million privately and publicly insured individuals, is used widely (including by state and federal governments), is one of only four qualified entities to utilize Medicare and Medicaid data, and provides the greatest transparency of pricing and costs in the health care market of any national database.

Creating Greater Transparency

In addition to rising out-of-pocket costs, patients often face frustration with a lack of transparency in the health care system, especially when it comes to understanding which physicians are currently in the network of their health insurance plan. Unfortunately, the accuracy of such information is highly inconsistent among insurers and even within the various plans of the same insurer.

PFC recommends requiring all insurers to update their provider network directories online at least monthly with easy access for all plan beneficiaries, and to perform an audit annually to ensure accuracy. Furthermore, health plans should be required to disclose a detailed description of the enrollee's health plan on their health insurance card to reduce errors and help providers properly adjudicate claims.

This includes the requirement that insurers disclose on the members' plan information and identification card, the state by which the plan is regulated, and the state laws it operates under, or if federally regulated, a requirement that it disclose that it is governed as a group benefit plan under federal law such as the Employee Retirement Income Security Act (ERISA).

Finally, we know that when patients are empowered to make their own decisions in the medical marketplace, quality can go up and costs can go down. This can better be achieved with greater price transparency, with one key to this being to require providers to share cost estimates of their health care services to patients.

In Conclusion

PFC advocates for and supports a ban on balance billing for unanticipated out-of-network care with strong patient protections, fair reimbursement backed by an Independent Dispute Resolution process to ensure access to care, greater network adequacy standards, and improved transparency for all patients.

We appreciate your leadership on this important issue and thank you for the opportunity to testify. PFC stands ready to work with you in the best interest of our patients and the physicians who care for them.