MSMS
MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw Street | East Lansing, Michigan 48823
517-337-1351 | msms@msms.org | www.msms.org

Testimony Before the House Health Policy Committee
Thomas J. Veverka, MD
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Thank you, Mr. Chairman and committee members for the opportunity to testify today. My name is Doctor Tom Veverka, I am a trauma surgeon from Saginaw, Michigan and I sit on the Michigan State Medical Society Board of Directors. I am testifying on behalf of the Michigan State Medical Society and our more than 15,000 members across the state in opposition to House Bills 4459 and 4460, as substituted.

We very much support the need to protect the patient from a surprise out-of-network bill. Our opposition to House Bills 4459 and 4460 is driven by the package's complete failure to address the multitude of factors that can lead to surprise billing and the implications it has for the in-network contracting landscape. While we have concerns with HB 4460, I will focus the thrust of my comments on the more problematic 4459 and defer to my colleagues to expound on 4460.

Again, MSMS is not opposed to addressing surprise out-of-network billing. In situations where a coverage gap occurs and patients unknowingly or without choice receive care from an out-of-network physician or other provider, they should be held harmless for any costs above their in-network cost-sharing. Patients should also be removed from any subsequent payment disputes between their health insurance company and an out-of-network provider when they experience an unanticipated gap.

What we are opposed to is health plans skirting responsibility for the products they sell to our patients including those with narrow networks, high-deductibles, and confusing cost-sharing obligations.

Much of the value of any health plan product lies in the robustness of the provider network. An unintended consequence of this legislation is that it will decrease the value of products purchased by patients, as it lowers insurer accountability and further incentivizes narrow and inadequate networks.

It is probably a surprise to no one that Michigan has the 6th least competitive insurance market in the country.[1] When an insurer exercises market power in its sale of insurance coverage as well as in its payments to health care providers, the quantity of insurance coverage provided is lower than in a competitive market. In short, the exercise of market power adversely affects health insurance coverage and care. This is an important point because it illustrates where Michigan is now. What we are proposing today will further tip the balance in favor of insurance companies that are currently enjoying "the golden age" of growth, sales and profits.

Michigan is also one of the lowest ranked states in terms of physician reimbursement. As we discuss the concept of contract negotiations, we should be clear that there is no true "negotiation" between physicians and insurance companies in Michigan. In the vast majority of cases it is "take-it" or "leave-it." Physicians are willing to discount their charges in exchange for in-network status, patient volume, and the assurance of statutory protections like prompt-payment penalties. When physicians are not part of a network, it is generally because

[1] According to the American Medical Associations' Competition in Health Insurance: A Comprehensive Study of U.S. Markets. The data used for this study were obtained from the Decision Resources Group (DRG) Managed Market Surveyor.

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we either have no choice or no bargaining power. We can be told a health plan's narrow network was full and isn't accepting new physicians.

The payers will say there are state regulations around network adequacy, to which we will say – show us the enforcement. There is no mechanism in law to enforce network adequacy in the state and to date, there has been no willingness to prioritize this issue as other states have done. This legislation could fundamentally change the insurance contracting landscape, as we are seeing most acutely in California where they have pursued a rate-setting approach. According to a RAND study published in the American Journal of Managed Care, the law has created an incentive for insurers in California to reduce or cancel contracts. If we go down this path, your constituents will need additional statutory protections, such as network adequacy requirements, than they are currently afforded under this bill.

What is perhaps most concerning is the impact this legislation could have on in-network contracting and specifically those physicians who are not involved in this problem. In its analysis of legislation introduced in the U.S. Senate, which includes a payment methodology benchmarking to the median in-network rate, the Congressional Budget Office states, "the vast majority of health care is delivered inside patients' networks, and more than 80 percent of the estimated budgetary effects...would arise from changes to in-network payment rates." In essence, in-network providers who have not contributed to the problem will bear the impact of the rate-setting scheme.

That should matter to every lawmaker sitting in front me today as it will likely lead to access problems for patients seeking hospital-based care from on-call specialists, as well as precipitate staffing shortages and widen the access gap in many rural areas and underserved communities around the state. I formally practiced in Saginaw and now practice in Midland. In both settings, this legislation may greatly hinder my ability to get on-call support from my colleagues. In areas of the state that are already facing issues around access to care and physician recruitment, this only serves to further erode the talent pool.

Finally, as written, this legislation is likely to have a direct impact on consolidation of health care, which, as we know is already a major cost-driver in our country. It is well-documented that physicians are finding it difficult to remain economically viable in independent practice and are moving to employment with higher cost private equity firms or hospital systems. According to the RAND study, as well as documented physician complaints, and physician surveys, of the experience in California, the law has exacerbated this trend and forced more physicians to seek assistance from larger systems, whose costs can be three times higher.

Even America's Health Insurance Plans is concerned about the anti-competitive impact of vertical consolidation ("when more and more of a region's doctors and medical experts work for the same hospital or health system") on rising health care costs, market competition, and consumer choice. In a statement[2] to the U.S. Senate Judiciary Committee Subcommittee on Antitrust, Competition Policy, and Consumer Rights this past June, AHIP stated the following:

[2] Accessed at https://www.ahip.org/wpcontent/uploads/AHIP_Statement_Senate_Judiciary_hearing_vertical_consolidation_06_12_19.pdf

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- "Every American deserves affordable coverage and high-quality care. The best way to achieve this goal is through a competitive health care system that offers a wide range of choices for accessing high-quality care at the lowest possible cost. When patients and consumers have more choice and more control, they can get the care they need when they need it, at a price they can afford."

- "A study published by *Health Affairs* in September 2018 found that the percentage of physicians in practices owned by a hospital increased from about 25% in 2010 to more than 40% in 2016 and, additionally, that the increase in vertical integration from 2013 to 2016 in highly concentrated hospital markets was found to be associated with a 12% increase in premiums."

Indeed, the legislation before us today is actually more restrictive than California as it does not include an independent dispute resolution (IDR) process or any sort of recourse for physicians if the payment isn't tenable and informal negotiations unravel. Meanwhile, our neighboring Midwest states, like Ohio, are pursuing more market-based approaches that include a dispute resolution process.

We implore lawmakers to carefully review the experiences of other states and consider a more comprehensive approach. We have openly advocated for a fair, IDR process with a timely, upfront commercially reasonable payment for out-of-network services. To be clear, this should only serve as a backstop in the event informal negotiations unravel. In states where IDR has been implemented the vast majority of cases are resolved outside the IDR process. Moreover, we know from objective analyses of experiences in other states of the cases that have gone to IDR, the decisions have been split down the middle. Concerns that an IDR will have an inflationary effect have not borne out in states where it has been implemented, in fact, a recent study conducted by health economists at Yale University shows physician payments have decreased in that state. To assuage some concerns, we would be supportive of allowing a variety of factors to be taken into consideration when determining the appropriate rate.

To reiterate, as other states have done, we implore you to consider additional statutory requirements around network adequacy that are clear and enforceable. We also encourage additional discussion around health benefit design transparency and requiring up-to-date provider directories.

Finally, if we are going to benchmark rates to the "average contracted rate" it must be transparent and derived from an independent claims database.

The majority of other states with out-of-network billing laws on the books require all parties that have contributed to this problem to take some responsibility for it. As written, these bills will make Michigan a clear outlier in favor of the insurance companies.

As always, we are happy to work with the bill sponsor and would hope to have a seat at the table moving forward in the process. I am happy to take any questions.