Testimony of

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I. Introduction

Madam Chair and esteemed committee members, thank you for the opportunity to speak to you today on a very important topic for our patients and for our physicians. My name is Dr. Sherif Zaafran. I am an anesthesiologist and Board Member of Physicians for FAIR Coverage, a national multi-specialty alliance of physician groups with five member groups in Oregon.

The issue at hand is certainly not new to this committee or its members. It has and continues to be one of profound importance, particularly when overlaid with the many healthcare challenges facing Oregon and our nation.

We appreciate the efforts by lawmakers to address solutions that protect our patients from large out-of-pocket personal expenses after receiving unexpected medical treatment and to bring clarity to the overall balance billing issue. While I will expound on this in more depth, it is important to frame the issue and understand why so many are impacted by balance bills.

Patients face these types of medical bills because of:

1) **insufficient coverage provided by insurer's inadequate and narrow networks forcing physicians out of network against their choice,**
2) **The high deductible, co-payment and co-insurance policies that are now becoming more and more popular with insurance companies.**
3) **Insurers offer physicians unacceptable take-it-or leave it reimbursement deals that can force them to practice out of network.**

While "surprise medical bills" might make for a nice headline, they are, in fact, a symptom of the larger problem, which is the surprise insurance gap. In my testimony, I'll talk about the surprise insurance gap and a comprehensive and fair solution to fix it.

Importantly, in emergency medicine, the surprise insurance gap is even more problematic than in non-emergency situations. Insurers are taking advantage of EMTALA rules to increasingly keep physicians out of network and to force physicians to accept whatever payment insurers choose to make creating that large gap in insurance coverage. EMTALA refers to The Emergency Medical and Treatment Labor Act, which says anyone must be treated at the emergency department regardless of their ability to pay.

The insurance company shell game is so opaque that even the savviest of patients have trouble navigating their rules. Many patients do the necessary research to ensure they have identified a hospital in their insurance network to go to in case of an emergency. However, the insurance companies through grossly inadequate provider networks make it extremely difficult for patients to navigate this process. Imagine you go to an in-network hospital only to find out that the doctor treating you is not in-network with your particular insurance product. It's not transparent and patients suffer.

Let's be clear: physicians practicing in emergency departments want to be in-network. The problem is insurers offer physicians either are not offered the opportunity to be in-network or are offered reimbursement plans way below what the market standard would be forcing providers to make the difficult choice to remain out-of-network. Isn't the very essence of insurance to assure appropriate protection especially in the case of an emergency?

II. Why We Are Here: The Surprise Insurance Coverage Gap

Let's be frank. Insurance Companies exacerbated the Out-Of-Network Balance Billing Issue in both emergency and non-emergency care. In emergency settings, this was done to shift costs for unexpected care that they should be responsible for covering.

Since enactment of the Affordable Care Act (ACA), the proliferation of narrow networks and tiered networks has led to significant gaps in insurance coverage resulting in more frequent episodes of out-of-network balance billing. Insurance companies are not negotiating in good faith with providers and are deliberately pushing providers out-of-network in an effort to improve their bottom line.

Furthermore, insurers are enticing consumers with lower premiums with little understanding that the tradeoff is unaffordable high deductibles, high copayments, and high out-of-pocket maximums with narrowly constructed networks. This in essence leaves patients significantly underinsured, further compounding the problem.

To reiterate, many insurance companies regularly pay significantly below market standards in out-of-network settings creating the large delta that results in a large payment gap, hence a large balance bill. At the exact same time, these same insurance companies are recording record profits but hiding it to justify these poorly designed insurance products.

It's been proven time and time again through litigation in the past – specifically in a lawsuit filed and won by New York State against Ingenix, a subsidiary of United HealthCare -- that insurance companies have manipulated their reimbursement rates artificially low, exacerbating the issue of large balance bills. And, it took the federal courts dealing with Aetna's planned merger with Humana to uncover the intentional hiding of profits as they dropped 700,000 patients from their networks.

III. A Comprehensive Solution

Today, I come before you to address this problem facing our patients with a solution, one that has been enacted and is working smoothly in other states, specifically, New York and Connecticut.

To address the underlying issue (the surprise insurance gap) AND the symptom (balanced billing), I respectfully recommend that any legislation proposed to solve this insurance gap and improve protections for patients include the following legislative guidelines. In so doing, you will be taking a more comprehensive approach, one that includes both:

- provisions that take the patients out of the middle of any dispute between insurance companies and providers – the only way to truly solve the problem -- and;
- fair payment for services based on an independent, non-profit, non-conflicted, transparent and verifiable database.

If the legislature only bans balanced billing without addressing fair reimbursement, the unintended consequences could be profound. Without addressing fair reimbursement, barriers to access to services will be erected. Rural Oregon, and medical deserts in urban areas, could be the most affected. If physicians aren't reimbursed adequately for services rendered, they simply cannot sustain their businesses. If physician practices go out of business, hospitals and emergency departments will not be adequately staffed. This is especially profound for rural areas which often lack adequate access to begin with.

Please also allow me to also address what I mean by "fair" reimbursement. Some legislative solutions in other states have pegged reimbursement for services to a percentage of Medicare. Unfortunately, the result is often woefully inadequate. The U.S. Government Accountability Office (GAO), the non-partisan investigative arm of Congress has, for example, established that Medicare significantly underpays physician anesthesiologists. Other states have pegged out-of-network rates to databases owned and controlled by insurance carriers. This can essentially lead to rate setting by insurance carriers.

Benchmarking reimbursements to a non-profit, non-conflicted independent database of billed charges within a geographic area is the only approach that makes sense. The benchmarked database should not be controlled or influenced by insurance carriers or physicians. We recommend use of the FAIR Health data base, as it is the only example of an independent database, free from influence and manipulation. It was established as the result of a lawsuit by New York State against insurance carriers that found these companies deliberately manipulating data significantly below market standards.

Physicians sincerely want to take the patient out of the middle, but to do so requires greater patient protections and fair reimbursement for both expected and unexpected out of network care by the insurers.

With this as a background, the specific legislative guidelines we believe any bill must contain to end the surprise insurance gaps and adequately address the problem of surprise bills are as follows:

- First and foremost, ***the patient should be held financially harmless*** for unexpected Out-Of-Network (OON) care.

- Any patient deductibles and cost-sharing for unexpected OON care should be applied to in-network cost sharing.

- An appropriate and fair standard should be created for out-of-network services that establishes a charge-based reimbursement schedule connected to an independently recognized and verified database, such as the FAIR Health database.

- Physicians should no longer submit balance bills to patients for unexpected out-of-network medical care when payments are tied to this independent database.

- When needed, mediation should occur only between the physician and the insurer, taking the patient out of the middle.

- Physicians should be allowed to initiate the mediation process and bundle claims in doing so. Mediation should be minimally tied to this independent database of charges.

- Greater transparency should be required of insurers. Specifically,
  - Network provider directories should be easily accessible for both patients and physicians, updated immediately and completely accurate, and
  - Patients should have access to information on the average charge, reimbursement rate, and expected out-of-pocket costs for any health care service or procedure in all geozips.

- Insurance carriers should be prevented from providing false, misleading and/or confusing information in regards to coverage.

In conclusion, Physicians for Fair Coverage and our coalition partners here in Oregon believe enactment of legislation addressing these guidelines is the solution to reducing costs and improving protections for our patients, while ensuring fair and reasonable reimbursement for physician services, hence preserving access to care.

Madam Chair, thank you for the opportunity to appear before you today. I am happy to answer any questions.