MSMS
MICHIGAN STATE MEDICAL SOCIETY

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Good Afternoon. Thank you Chairman Iden and members of the committee for the opportunity to testify. My name is Bobby Mukkamala. I am an otolaryngologist from Flint, Michigan, and the President of the Michigan State Medical Society.

Surprise, Out-of-network billing is an important topic, and I am happy to be here today to talk a little bit about the physician perspective. The physician community agrees patients should be protected from surprise, out-of-network medical bills. A surprise, out-of-network medical bill occurs when a patient has insurance coverage, goes to a hospital that is in-network, but is treated by a physician that is ***not*** in the insurance company's network. Often, the patient has done everything right to avoid a surprise medical bill but gets stuck with the bill in the end. This is a national problem and let me repeat, we agree that patients should be **protected** from that surprise.

Now, I would just like to briefly talk about why Michigan is different than other states. Blue Cross Blue Shield of Michigan has 66 percent of the overall market share in Michigan. According to the BCBSM website, for their PPO product, every single hospital in the state of Michigan contracts with BCBSM, as well as 95 percent of the state's physicians. For their HMO product , enrollees have access to 6,100 primary care physicians and 22,7000 specialists in the state. Surprise, out-of-network billing should not be an issue for members of BCBSM, by far the largest insurer in the state of Michigan. We, as the physician community, have real concerns that the legislation before you will do significant harm to patients for many reasons. Let me just describe a few potentially very negative consequences of these bills.

1. Just because a medical bill is surprising, does not mean it is out-of-network. The surprise often is due to poorly understood coverage and the SURPRISE of realizing what a $5000 or $10000 deductible actually means. This bill does nothing to address that. This might solve the out-of-network problem, but it does not solve the more far-reaching and frequent high-deductible problem.

2. California's out-of-network law took effect in July of 2017, and without a robust Independent Dispute Resolution (IDR) process, the California Department of Managed Health Care shows consumer complaints about access to care have risen by 48 percent. There is a better way to solve this issue and make sure that better networks are built.

The legislation you are considering today completely negates a physician's ability to negotiate fair rates, especially with the biggest insurers in the state. What we have before us puts me, an otolaryngologist who performs surgery, in the position of either accepting the insurance companies first offer or accepting the out-of-network rate that is defined in this bill package. The solution should *incentivize* insurance companies to support a robust network; thereby, ensuring patient access to appropriate, timely, and affordable care in emergent and non-emergent situations.

When given the opportunity to pay out-of-network physicians the same or less, insurance companies across the country did exactly what we are trying to avoid: shrunk their networks and kicked doctors out. As physicians are forced out-of-network, patients could face challenges in finding in-network providers and push patients toward receiving out-of-network care. Importantly, receiving this out-of-network care would result in a significant increase in patient deductibles and out-of-pocket costs, which is the opposite of the intended impact of this legislation. Our solution to this problem in Michigan should incentivize plans to keep physicians in network and disincentivize further consolidation of medical practices by hospitals and private equity firms.

That is the reality being borne out in California. In addition to less patient access to care, California has also seen significant provider consolidation. According to the American Journal of Managed Care, (and I quote) "although the payment standard in AB-72 applies only to OON providers, stakeholders report that it is having substantial effects on hospital-based physicians who historically contracted with payers." If a contract is offered to doctors that is well below what is reasonable, the ability to not sign it and bill for services is removed because those doctors will be forced into the lower rate anyway. Leverage is being removed from the doctor caring for these patients in an emergency room or operating room in the middle of the night, and instead being handed to the insurance company administrator in their office Monday through Friday from 9 am to 5 pm.

While we as the physician community share our patients' concerns about receiving surprise, out-of-network bills, there is more to be considered. This is about further consolidating leverage with an already minimally competitive insurance market to drive down physician rates in a time when, quite frankly, we need physicians more than ever as the world battles viruses, diabetes, obesity, and whatever tomorrow brings. We want a healthier Michigan and that means making sure we have the doctors here to make it so.

One of the main issues at hand here is the availability of an independent process to resolve disputes between physicians and insurers, a critical piece of the solution. The Michigan State Medical Society has advocated for the inclusion of independent dispute resolution (IDR) as the solution to surprise out-of-network billing since day one. This process removes the patient from the middle and allows a fair negotiation between the provider and the insurance company.

MSMS appreciates that Chairman Iden and Representative Hauk, heard our advocacy and included a form of arbitration in the bill. During a recent stakeholder meeting, we expressed our concerns with the specific language, including the structure and narrowness of the outlined process. For example, the bill asks for proof that the network was inadequate. It is not within the purview of individual physicians to investigate and prove network adequacy. Also, physicians would first have to appeal to the insurance company that already refused to negotiate a reasonable rate, and then only a subset of complex claims would be eligible for consideration by an independent arbiter, adding unnecessary administrative costs and roadblocks.

In good faith, MSMS pledged to draft alternative language as a compromise between our original preferred IDR language and the language proposed in the draft substitute. Amended language was presented ahead of this committee hearing to allow a physician to ask for IDR given the complexity and circumstances of an individual case, if there was a claim over $1,000, or if there were similar claims from the same provider that totaled over $1,000. If any of those criteria are met, the provider and insurer would have their case heard by an independent arbiter that would evaluate certain criteria. It is important to note, in the MSMS proposal, the loser of the arbitration would pay the full rate of arbitration. The goal being to incentivize both parties to come with their best offer and avoid future arbitration. Don't like what we want to pay? Don't like what my charges are? Fine. Let's have an independent entity evaluate those numbers and make a decision that will bind both of us. Eventually, it becomes predictable what the arbiter will say, and the market rate will be set.

Physicians and other health care team members have long been advocates for our patients when insurers have denied or delayed covered, evidence-based care. We would offer that if health plans truly have the best interests of patients in mind, a discussion of a comprehensive patient protection package which is inclusive of prior authorization reform is warranted.

Again, MSMS appreciates the opportunity to bring our concerns to your attention and respectfully, ask you to reconsider the one-sided solution to surprise medical bills before you today.

Thank you for your time and consideration. I am happy to take any questions.