October 29, 2019

The Honorable Lana Theis
Chairwoman
Michigan State Senate Committee On Insurance And Banking
PO Box 30036
Lansing, Michigan 48909

Dear Chairwoman Theis:

The American Osteopathic Association (AOA) and the Michigan Osteopathic Association (MOA) are writing to thank you for your commitment to protecting patients from unanticipated medical expenses via SB 570 and SB 572, and to request several important changes to the legislation. The AOA and MOA strongly support the goal of ensuring that patients can access the care that they need in a timely manner without fearing that they may later receive catastrophic medical bills for expenses that they reasonably believed were covered, or for emergency out-of-network services. We support holding patients harmless from unexpected bills in such circumstances, but we are deeply concerned that without accompanying protections to promote insurance network adequacy and transparency, and a fair payment negotiation and dispute resolution process for physicians and insurers, these bills may have the unintended consequence of further reducing access to affordable, quality health care for patients.

The AOA proudly represents its professional family of 145,000 osteopathic physicians (DOs) and medical students nationwide. The AOA promotes public health, encourages scientific research, serves as the primary certifying body for DOs and is the accrediting agency for osteopathic medical schools. More information on DOs/osteopathic medicine can be found at www.osteopathic.org. MOA is a professional organization that represents over 6,000 DOs providing patient care in Michigan.

Core principles of osteopathic medicine emphasize the provision of patient-centered, coordinated care across the healthcare continuum. These same principles also inform our organizations' perspective on the legislation being considered by this committee. The AOA and MOA are focused on promoting patient access to high quality, physician-led care wherever they live, and fairness for patients and physicians when dealing with out-of-network charges for services that the patient

reasonably believed to be in-network, or in emergency situations when such decisions are impractical (if not impossible).

SB 570 and SB 572 help to address the issue of patients receiving unanticipated medical bills; however, as written, they fail to address some of the underlying market dynamics that give rise to surprise out-of-network bills in the first place. Unsustainably low in-network rates offered by some insurers can create obstacles to physicians' ability to participate in those insurers' networks. When such an insurer is the only carrier in an area, physicians are particularly disadvantaged by having no other networks to join, which can further exacerbate the lack of specialty physicians in rural and underserved communities. In some cases, these rates are insufficient to even cover the cost of health care delivery by the provider.

These bills follow a similar approach to the aforementioned unsustainable approach followed by insurers by creating their own arbitrary fee schedule that out-of-network physicians would berequired to accept. This further diminishes the need for insurers to negotiate contracts in good faith and effectively sets a payment ceiling, even if these rates would to be adjusted for inflation. Knowing that any physician who is unwilling to accept in-network rates would be nonetheless bound by this payment ceiling (and therefore have no effective leverage) further disincentivizes insurers from developing contracts to expand their network.

We would also urge the committee to take into account the mandate placed on physicians under the federal Emergency Medical Treatment and Labor Act (EMTALA), which guarantees access to emergency medical care, regardless of a patient's insurance status or ability to pay. Coupled with EMTALA, SB 570 and SB 572 would create a dual mandate where physicians are required to provide emergency care while also accepting a low payment ceiling, should they not agree to an insurance company's proposed terms. This could further disincentivize physicians from practicing in areas where they are most needed by making medical practice economically unsustainable.

As an alternative to the approach proposed in these bills, the AOA and MOA request that the committee consider a benchmarking formula that takes into account actual local charges, as determined through an independent claims database. The inclusion of actual local charges in a benchmarking formula would remove the incentive insurers have to drive reimbursement rates to unsustainably low levels because there will no longer be a benchmark ceiling created by the arbitrary fee schedule described in these bills.

In addition, we would like to request the inclusion of an appeals process in the legislation to address disputes that may arise between insurers and physicians. Currently, several states have implemented laws aimed at protecting patients from surprise bills when procedures are performed by out-of-network physicians, while also supporting the sustainability of physician practices.

For example, New York's appeals process has reduced the rate of out-of-network billing for emergency department services from 20.1% in 2013 to 6.4% in 2015, a near 70 percent reduction.[1] Additionally, the process has completely removed patients from the middle of any dispute. This process allows patients to receive needed care without being burdened with unexpected medical bills, and supports physicians in focusing on treating patients.

Further, we encourage the committee to strengthen health insurance network adequacy. In recent years, more patients have found themselves in plans with narrow provider networks as employers have chosen to shift to plans with skinnier networks[2] and narrower network options are offered on state exchanges.[3] Quite simply, narrow networks result in more physician being driven out of network. These plans limit choice for consumers, create access challenges to affordable care, and contribute to the issue of patients being forced to accept out-of-network care in emergency rooms.

Overly narrow provider networks contribute significantly to out-of-pocket costs and access challenges. Strong oversight and enforcement of network adequacy is needed from federal and state governments. A study published in *JAMA* in 2015 found that nearly 15% of health plans were specialist deficient, and beneficiaries of specialist deficient plans had high out-of-network costs. More than a quarter of these plans did not cover out-of-network services and the remainder required 50 percent cost sharing.[4] This is especially concerning in rural areas where access to both providers and coverage options are limited.

Strengthening network adequacy standards will protect patients and lower out-of-pocket costs. Robust network adequacy standards include, but are not limited to, an adequate ratio of emergency physicians, other hospital-based physicians, and on-call specialists and subspecialists to patients, as well as geographic and driving distance standards and maximum wait times.

The AOA and MOA thank you for considering our comments, and urge you to consider a comprehensive, balanced solution to the issue of unanticipated out-of-network bills that protects patient access to timely, high-quality care. Should you need any additional information, please feel free to contact Raine Richards, JD, Director, State Government Affairs at rrichards@osteopathic.org or (312) 202- 8199.

Sincerely,

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[1] Cooper, Z,; Morton, F.S.; and Shekita, N. (2017). *Surprise! Out-of-Network Billing for Emergency Care in the United States*. National Bureau of Economic Research, http://www.nber.org/papers/w23623.pdf.
[2] https://www.aap.org/en-us/Documents/gettingpaid_emergingtrends_private_insurance.pdf
[3] https://avalere.com/press-releases/health-plans-with-more-restrictive-provider-networks-continue-to-dominate-the-exchange-market
[4] Dorner SC, Jacobs DB, Sommers BD. Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act. *JAMA*. 2015;314(16):1749–1750. doi:10.1001/jama.2015.9375

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