Twitter Thread by Dan Choi, MD

Dan Choi, MD
@drdanchoi

THREAD - Doctors want to fix “surprise bills” more accurately called unpaid insurer bills but today’s “agreement” is NOT the right fix for patients

It’s just a big boost to insurer profits & will shutter independent physician practices & rural hospitals!

1/x

> Just joined other House and Senate leaders in announcing a surprise billing agreement. Under this agreement, the days of patients receiving devastating surprise out-of-network medical bills will be over. https://t.co/HELY6OiPtS
>
> — Rep. Frank Pallone (@FrankPallone) December 12, 2020

The Independent Dispute Resolution (IDR) in this compromise directs arbiter to consider “in network median rates” when settling disputes which is a sham arbitration & tantamount to benchmarking aka rate setting

Who dictates in network rates?

Insurers!

2/x

This bill prohibits use of charge data (aka usual & customary) which is another way of saying doctors must accept whatever poor contract terms or low balled payment offers insurers are jamming down their throats

This is just giving more power to profitable insurers

3/x

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forts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

"(D) PROHIBITION ON CONSIDERATION OF BILLED CHARGES.—In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges or the

amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 2799B–1 or 2799B–2 (as applicable) not applied.

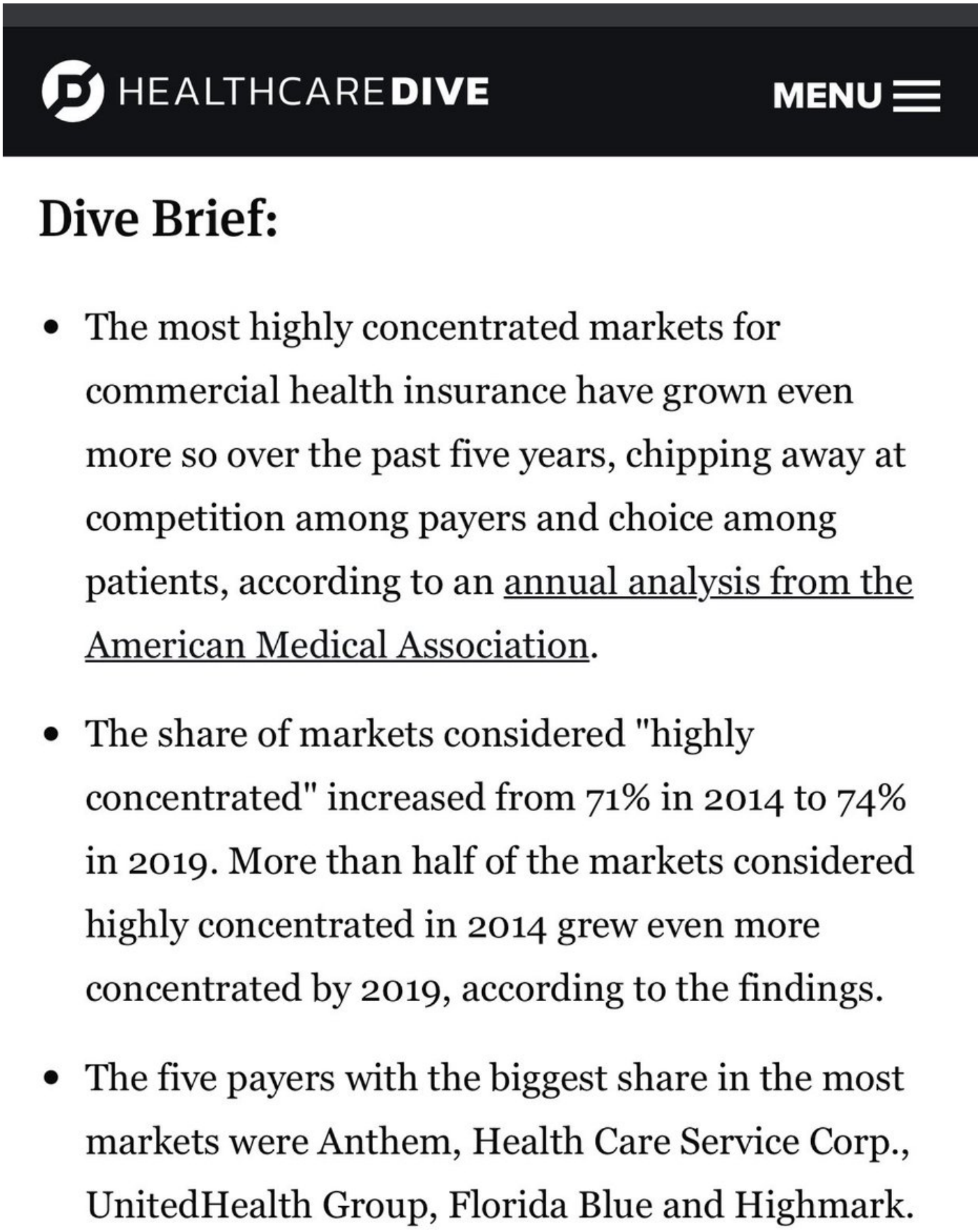
"(E) EFFECTS OF DETERMINATION.—

"(i) IN GENERAL.—A determination of a certified IDR entity under subparagraph (A)—

"(I) shall be binding; and

The reason why arbitration works in states like NY, TX is that it levels playing field, directs arbiters to consider independent price database like @FAIRHealth that can't be manipulated by either side

Insurers have total control over "median in network" rates w their monopolies



When insurers have control over terms of arbitration, they will do everything in their power to do what any respectable publicly traded corporation will do: tilt the terms in their favor to increase profits

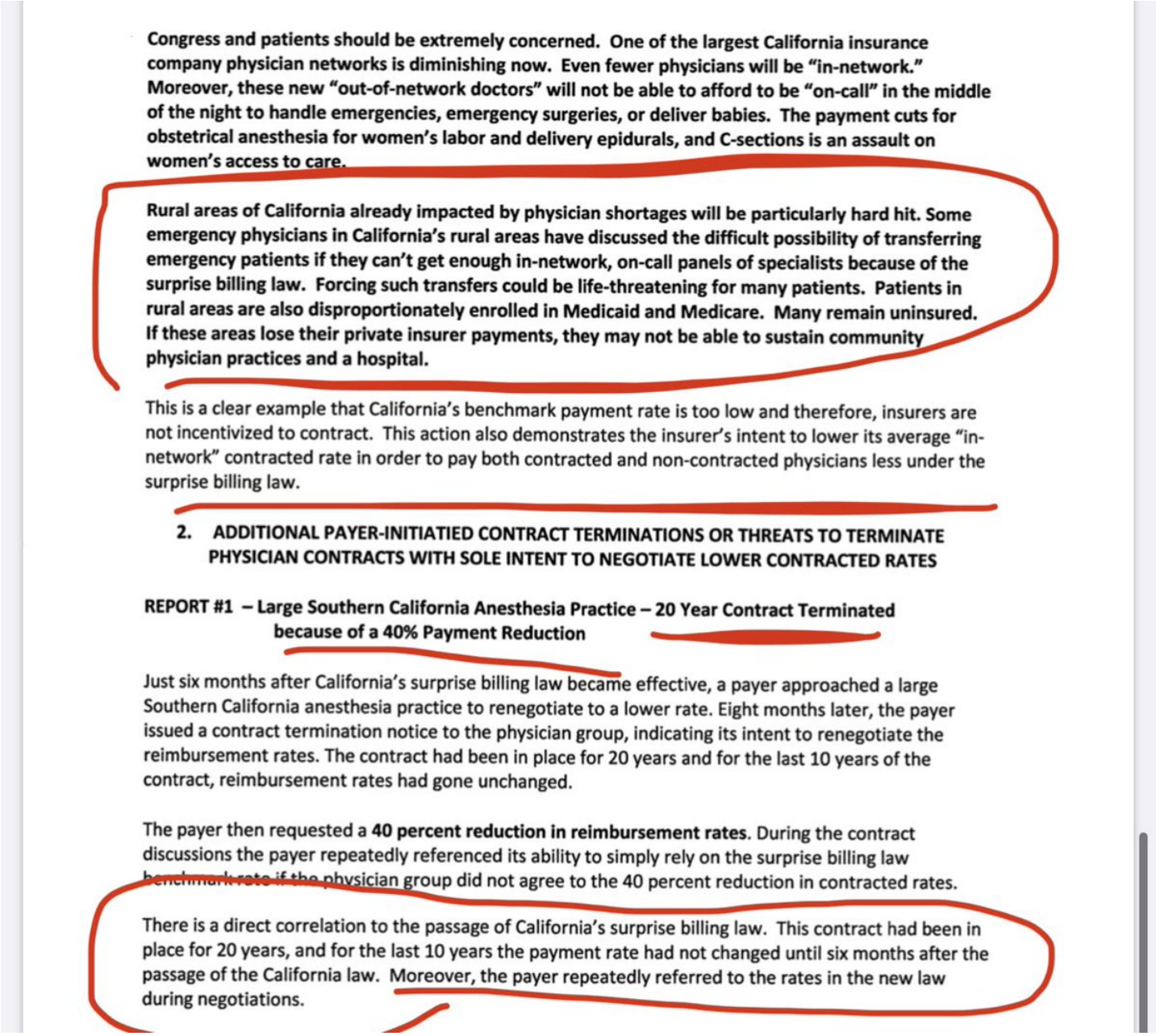
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https://t.co/NfgMrWNoq5

In CA, insurers started terminating contracts with physician groups overnight to drive down in network median rates

Independent practices had to shutter their doors or join large health systems to survive. Consolidation drives up costs! Rural areas were hit hardest.

6/x



Congress and patients should be extremely concerned. One of the largest California insurance company physician networks is diminishing now. Even fewer physicians will be "in-network." Moreover, these new "out-of-network doctors" will not be able to afford to be "on-call" in the middle of the night to handle emergencies, emergency surgeries, or deliver babies. The payment cuts for obstetrical anesthesia for women's labor and delivery epidurals, and C-sections is an assault on women's access to care.

Rural areas of California already impacted by physician shortages will be particularly hard hit. Some emergency physicians in California's rural areas have discussed the difficult possibility of transferring emergency patients if they can't get enough in-network, on-call panels of specialists because of the surprise billing law. Forcing such transfers could be life-threatening for many patients. Patients in rural areas are also disproportionately enrolled in Medicaid and Medicare. Many remain uninsured. If these areas lose their private insurer payments, they may not be able to sustain community physician practices and a hospital.

This is a clear example that California's benchmark payment rate is too low and therefore, insurers are not incentivized to contract. This action also demonstrates the insurer's intent to lower its average "in-network" contracted rate in order to pay both contracted and non-contracted physicians less under the surprise billing law.

2. ADDITIONAL PAYER-INITIATIED CONTRACT TERMINATIONS OR THREATS TO TERMINATE PHYSICIAN CONTRACTS WITH SOLE INTENT TO NEGOTIATE LOWER CONTRACTED RATES

REPORT #1 – Large Southern California Anesthesia Practice – 20 Year Contract Terminated because of a 40% Payment Reduction

Just six months after California's surprise billing law became effective, a payer approached a large Southern California anesthesia practice to renegotiate to a lower rate. Eight months later, the payer issued a contract termination notice to the physician group, indicating its intent to renegotiate the reimbursement rates. The contract had been in place for 20 years and for the last 10 years of the contract, reimbursement rates had gone unchanged.

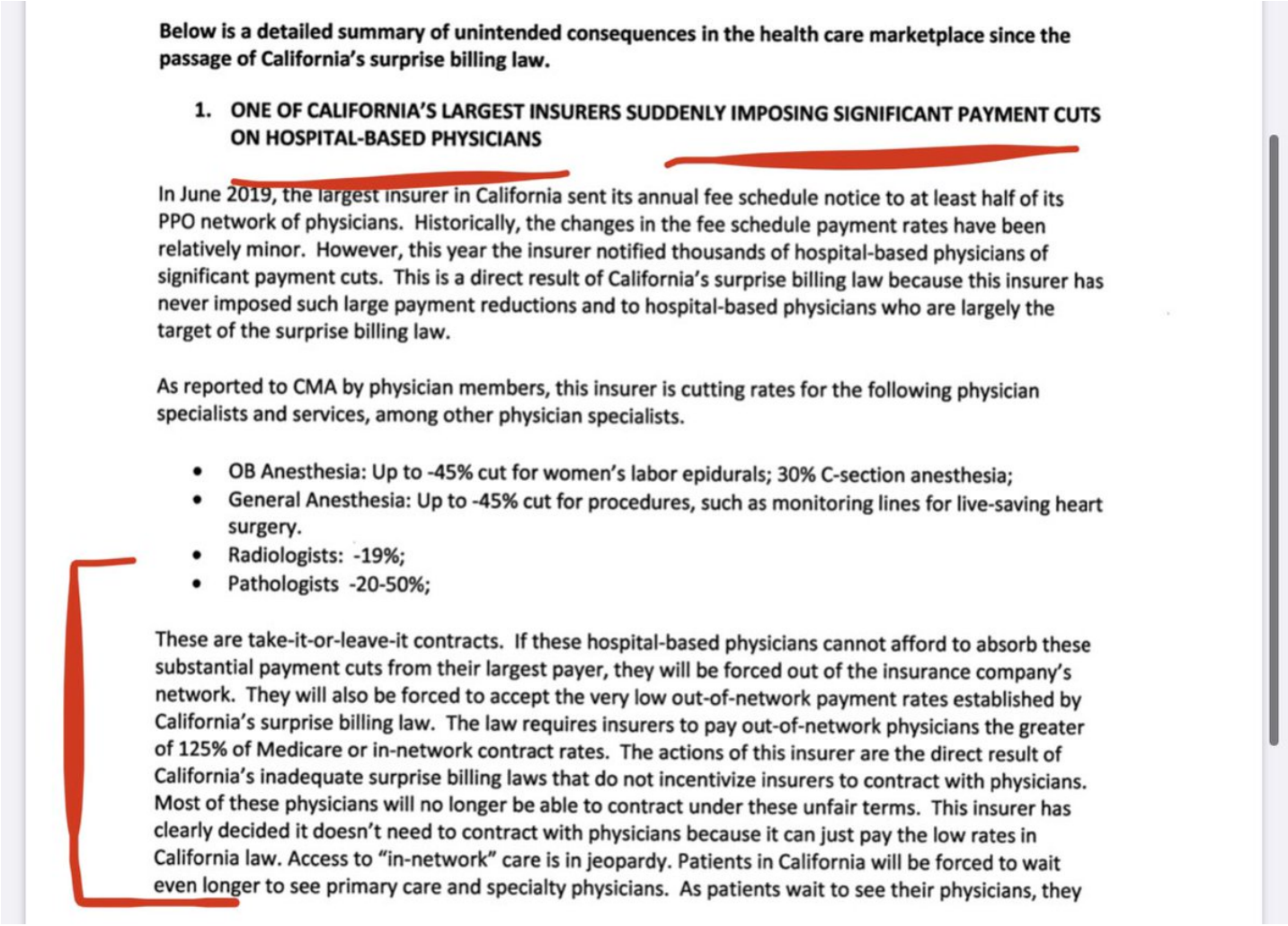
The payer then requested a **40 percent reduction in reimbursement rates**. During the contract discussions the payer repeatedly referenced its ability to simply rely on the surprise billing law benchmark rate if the physician group did not agree to the 40 percent reduction in contracted rates.

There is a direct correlation to the passage of California's surprise billing law. This contract had been in place for 20 years, and for the last 10 years the payment rate had not changed until six months after the passage of the California law. Moreover, the payer repeatedly referred to the rates in the new law during negotiations.

When out of network payments are tied to in network rates, there is literally no option for providers to fight back against unfair take it or leave it contracts that insurers design to ■■ profits

Tying arbitration to “median in network” rates gives insurers ALL the leverage

7/



Below is a detailed summary of unintended consequences in the health care marketplace since the passage of California’s surprise billing law.

1. **ONE OF CALIFORNIA’S LARGEST INSURERS SUDDENLY IMPOSING SIGNIFICANT PAYMENT CUTS ON HOSPITAL-BASED PHYSICIANS**

In June 2019, the largest insurer in California sent its annual fee schedule notice to at least half of its PPO network of physicians. Historically, the changes in the fee schedule payment rates have been relatively minor. However, this year the insurer notified thousands of hospital-based physicians of significant payment cuts. This is a direct result of California’s surprise billing law because this insurer has never imposed such large payment reductions and to hospital-based physicians who are largely the target of the surprise billing law.

As reported to CMA by physician members, this insurer is cutting rates for the following physician specialists and services, among other physician specialists.

- OB Anesthesia: Up to -45% cut for women’s labor epidurals; 30% C-section anesthesia;
- General Anesthesia: Up to -45% cut for procedures, such as monitoring lines for live-saving heart surgery.
- Radiologists: -19%;
- Pathologists -20-50%;

These are take-it-or-leave-it contracts. If these hospital-based physicians cannot afford to absorb these substantial payment cuts from their largest payer, they will be forced out of the insurance company’s network. They will also be forced to accept the very low out-of-network payment rates established by California’s surprise billing law. The law requires insurers to pay out-of-network physicians the greater of 125% of Medicare or in-network contract rates. The actions of this insurer are the direct result of California’s inadequate surprise billing laws that do not incentivize insurers to contract with physicians. Most of these physicians will no longer be able to contract under these unfair terms. This insurer has clearly decided it doesn’t need to contract with physicians because it can just pay the low rates in California law. Access to “in-network” care is in jeopardy. Patients in California will be forced to wait even longer to see primary care and specialty physicians. As patients wait to see their physicians, they

We need to model federal bill like NYS where IDR is fair & based on charges

“From 2015-2018, the Out of Network Law saved NY more than $400 mil in emergency services, reduced out-of-network billing by 34%, lowered in-network ED physician payments by 9%”

https://t.co/HhqkTkB4Fe

NYS surprise bill law has not caused any physician shortages as opposed to huge shortage exacerbated in CA

NY’s surprise bill saved consumers $400 mil per @NYGovCuomo @NYDFS

In CA consumer complaints re access to care skyrocketed after benchmarking implemented

9/x

Press Release

September 17, 2019

GOVERNOR CUOMO ANNOUNCES SUCCESS OF NEW YORK'S LANDMARK OUT-OF-NETWORK LAW PROTECTING CONSUMERS FROM SURPRISE MEDICAL BILLS

Department of Financial Services Report Finds Growing Number of Decisions for Independent Dispute Resolution, Growing from 149 in 2015 to 1,148 in 2018

The OON Law has Saved Consumers More Than $400 Million in Costs Related to Emergency

Insurers even love the NY law. They even personally endorsed the law!

10/x

New York HPA Health Plan Association

41 State Street • Suite 900
Albany, NY 12207-
518.462.2293
www.nyhpa.org

NEWS RELEASE

FOR IMMEDIATE RELEASE:
October 17, 2019

CONTACT:
Leslie S. Moran
518.462.2293
(cell) 518.588.6655

NEW YORK HEALTH PLAN ASSOCIATION ON SIGNING OF HOSPITAL OUT-OF-NETWORK LEGISLATION

Statement by Eric Linzer, HPA President & CEO

"Today's signing of A.264-B/S.3171-A and A.8404/S.6544-A will help protect patients from excessive emergency charges by closing a loophole in the current law that had excluded hospitals.

"The existing Independent Dispute Resolution process has worked well to ensure reimbursements for emergency services are fair and reasonable while holding individuals harmless. Unfortunately, the original law did not include charges from out-of-network hospitals, leaving patients saddled with significant unanticipated out-of-pocket costs from some institutions far in excess of what would be considered reasonable.

"Adding emergency hospital services will provide consumers with relief from unwarranted and excessive surprise medical bills. This is a balanced approach in extending the law and providing an important safeguard for New Yorkers."

-30-

The New York Health Plan Association represents 29 managed care health plans that provide comprehensive health care services to more than 8 million New Yorkers.

Remember Congress has a bill modeled after successful NY law that has a fair IDR

HR3502 by @DrPhilRoe @Dr_RaulRuiz already has 110 cosponsors but House and Senate leadership continues to ignore!

11/x

https://t.co/c7t6qnsuXJ

In conclusion, doctors want an end to unpaid insurer bills aka 'surprise' bills ASAP

This agreement though is unacceptable - benefits insurers only & will crush independent practices & rural hospitals. Will drive consolidation, ■■ cost, exacerbate access to care problems

12/x

We need to fix “surprise medical bills” the right way with a fresh start in January

@SenSchumer @SpeakerPelosi @senatemajldr @RepKevinBrady @RepRichardNeal

/end

■■ @EdLaborCmte
@EdLaborGOP
@BobbyScott
@GOPHELP
@SenateHELP
@SenateFinance
@SenFinance
@SenateApprops
@WaysMeansCmte
@EnergyCommerce
@WaysAndMeansGOP
@HouseCommerce
@AppropsDems
@HouseAppropsGOP
@HouseBudgetDems
@HouseBudgetGOP
@HouseGOP
@HouseDemocrats
@WhipClyburn

■■ @LeaderHoyer
@GOPLeader
@senatemajldr
@SenJohnThune
@SenJohnBarrasso
@SpeakerPelosi
@SenSchumer
@LeaderHoyer
@WhipClyburn
@SenatorDurbin
@PattyMurray
@SenStabenow
@amyklobuchar
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