

**TESTIMONY OF PATRICIA A. McLAUGHLIN, M.D.**  
**AT A HEARING OF**  
**THE US HOUSE OF REPRESENTATIVES**  
**OVERSIGHT AND GOVERNMENT REFORM COMMITTEE**  
**DECEMBER 12, 2013**

My name is Dr. Patricia A. McLaughlin, M.D. and I am an ophthalmologist in a solo practice in New York City. I sincerely appreciate the opportunity to share, with the Committee, the difficulties I am experiencing with the implementation of health care reform and, more importantly, the impact this will have for my patients and my employees and my business operations. My comments and concerns will be made outside the political debates, as these ultimately have no business in the doctor-patient relationship. My concerns are, first and foremost, for those that need and seek medical care. My responsibility is to take the knowledge handed down through years of supervised training, and ethically and morally deliver the best that I have to offer, to a patient seeking help to prevent or treat an illness or accident.

Regardless of a physician's individual perspective of the new health care law, physicians are only beginning to recognize the sudden and massive upheaval to business, as usual that is to come as of the first of January, 2014. Health insurance companies have been rather late in the game in announcing their creation of new limited networks, which will offer only in-network benefits. This, shockingly, is affecting long-standing health insurance plans with excellent benefits that served Small Business groups, such as mine, as well as plans offered to individuals through various State Exchanges and the Healthcare.gov site.

My personal story unfolded in late September, 2013. I received written notice from Empire BCBS that the health insurance plan, I provide myself and my employees would not be renewed on the anniversary date of 1/1/14. The reason given was that there were components that did not comply with the Affordable Care Act (ACA). I was reassured, as the Administrator of my small business group coverage that the insurance company was preparing to roll out a new plan, which would be similar to my existing plan, and would be in compliance with the ACA requirements. In the interim, I was further advised to consider researching other offerings for Individuals and Small Businesses on the NY Exchange Marketplace. All of this was surprising to me, as my plan was quite comprehensive and included both in and out-of-network benefits.

Near the end of October, the new plan was described. Two major differences were noted immediately: the first was that this was to have only in-network coverage, an EPO plan, and the already high deductible of \$2000.00 per individual, was about to increase to \$2500.00 annually. Cost sharing, co-insurance would remain the same at 80/20. While the deductible increased \$500.00, the out-of-pocket cost was to decrease by the same amount. The new premium was slightly decreased, less than \$20.00 a month. On the surface, this did not sound so disturbing, but the extra deductible was going to cause a definite hardship for all concerned.

Re-reading this introductory letter several times raised more serious concerns. The insurance company was stressing the need to check with current doctors, who had been in-network with the terminated plan, to see if they would be participating in the new "Pathway" network. In spite of my familiarity with this insurance company, myself a participating physician with them since going into practice in 1993, I found it odd that a "new" EPO plan would be having a different and apparently far more limited network of participating physicians from the current EPO/PPO networks for present day insurance plans. Yet that is the reality. In addition, the approved formulary drug list, in the new EPO Small Business plan was also going to be more restricted than the plan phasing out for my group on 12/31/13. These points were certainly missed by me, on the first pass, and I am quite familiar with this type of information. I am concerned that other Small Business Administrators, in non-medical businesses, may not appreciate the significance of the limited network.

As if this wasn't enough, I then received notice last month from the same insurance company addressed to me as a participating physician, that due to the terms of my contract, I would not be extended participating status on the new insurance plans covering the Individuals on and off the Exchange or for the new HMO/EPO Small Business plans beginning on 1/1/14, all using the "Pathway" network. No reason was given, other than there was no need for them to offer participation at this time. However, they still will consider me to be a participating physician in their other BCBS plans off the Exchange that essentially cover large businesses, government workers, and Small Business plans yet to reach their anniversary date until later on in 2014.

At that point, I decided to investigate the Web site for the Empire BCBS Pathway network, listing those doctors that would be the ones my employees would need to use if I decided to take on this new EPO group plan. Amazingly, all of us would lose our primary care physician, unless we elected to see him on a completely non-covered private arrangement. Since our new plan is only to have in-network benefits, these costs would not go toward satisfying either the deductible or the out of pocket maximum. My employees also see specialists, and again, none of their current specialists were in the new "Pathway" network. This is alarming. No patient should have to give up all the doctors that they trust and with whom they have had long-standing doctor-patient relationships over many years. We all cherish our freedom of choice, but to maintain the doctor-patient relationship, while insured, with all out-of-pocket

costs coming from the patient, seems to have been an unintended consequence of an attempt to pass a law to cover individuals without insurance and/or pre-existing conditions in an affordable manner. This instead has turned into a house of cards about to fall affecting the lives of millions and severing doctor-patient relationships over and over again.

All insurance participating physician offices will need to be on high alert booking appointments after 1/1/14 to question the patient about changes in insurance coverage that could affect their ability to remain in the practice if they only wanted to use in-network benefits. If we found this out only when the patient presents to the office, the patient would naturally be disappointed and perhaps angry. They may not be in a financial position to pay for services without any reimbursement from insurance, if only to satisfy the deductible, which this situation clearly would not permit with all in-network plan offerings.

Exacerbating this problem is that almost all health insurance plans to be offered, completely eliminate out-of-network coverage altogether. For the limited few plans that offer an out-of-network benefit, some insurance company quotes that I have been reviewing are now lowering that benefit to a fixed amount, equal to 110% of the already low\_Medicare allowed fees, which in the New York City area can often only be a small fraction of usual charges. The balance of the doctor or facility bill then becomes the patient's responsibility. With such limited out-of-network payouts from insurance companies to the member, how can this be "too expensive to offer?" Clearly, the almost extinct Indemnity Plans of years gone by paid out using geographically determined reasonable and customary fees with 90/10, 80/20, or some other cost-sharing amount. The newer method comes in far lower and, again, puts a greater responsibility on the patient that chooses or needs to go to a physician or facility out-of-network. So why were all these Healthcare.gov and Exchange Marketplace insurance plans made to have such limited networks and no out-of-network benefits? In my opinion, this will slow down health care spending, simply because the patients will have to wait weeks or possibly longer to access a physician or facility that is in-network. These in-network physicians are already seeing a maximum number of patients per session. How are they going to take on so much more responsibility? Moreover, this gives so much more ability to control care by the insurance company, and takes away clinical control from the physicians who are able to be in these networks.

I estimate that I could easily lose 20% or more of my current patients that currently are insured through Healthy New York and other Individual contracts, both of which were eliminated with the roll-out of the health care reform law. Where will they be able to seek care? My doors will always be open for them and I shall do everything possible to see to it that my patients will receive the care they need. After all, physicians care about their patients. There should be no imposed barriers to access care. The patient's life may depend on a timely response to treatment. This must be fixed immediately. "There for the grace of God, go I." Even, I, as a physician, may require urgent care one day.

The other part of the problem I see from reviewing the NY Exchange Marketplace insurance offerings, applicable to all new ACA plans across the Nation, is the shockingly high deductibles. Yes, certain, individuals of lower income will qualify for government subsidy to offset the monthly premiums and the deductibles. However, many middle class people, living and working near my office, will not qualify for a subsidy, and are paying rents for studio apartments greater than \$2000.00 per month. These hard working individuals can ill afford a first dollar expense associated with the Bronze level plans calling for a \$3000.00 deductible before there is any insurance cost sharing. To add to this, the Bronze level plans seem to also expect the patients to pay 40-50% co-insurance on the allowed in-network amount. The only information out there for the public to hear is that these plans are so inexpensive. Many individuals, who never had insurance, do not even understand the concept of a “deductible” and “co-insurance.” Insurance law compels the in-network participating physician to bill the patient for deductibles and co-insurance. These bills are going to come as sticker shock to patients since they have no prior experiences. They will be hard-pressed to meet this financial responsibility. In clinical practice today, we have seen such behavior with the use of consumer driven health plans when the employee and/or employer did not set up an HSA or HRA account to offset the high deductible expense. Ultimately, this will significantly drive up collection costs, potentially threatening physician practice viability, but perhaps more significantly, it discourages patients from availing themselves of getting needed care because of these potential out of pocket costs.

It is very important to understand that expenses to run medical offices have skyrocketed. The monthly maintenance for my office has doubled from \$2900.00 per month to \$5700.00 per month in 13 years. Every invoice related to the operation of my business has seen a double-digit increase in the past two years. New York State physicians pay among the highest liability premiums in the country. Ironically, due to the flawed SGR formula affecting Medicare payments to doctors, income for physicians has actually decreased. The insurance companies have also decided to use the Medicare fee schedule as the point of reference for all ‘negotiated’ participating fees. Thus, what happens to Medicare actually directly affects all the commercial fee schedules. We are seeing many physicians, especially, primary care physicians, closing their private practices and joining faculty practices in hospitals or large physician groups. They are doing this because the days of joy in a solo practice are now filled with concern over the ever increasing overhead costs. Our employees are a dedicated team but are facing long hauls of no salary increases because we simply are struggling to keep the lights on so we can continue to deliver the care. We have stuck with this to be there for the patients.

The doctors enrolled on the Exchange plans are telling grave tales of FAR lower reimbursement from the very same insurance network ‘ON’ the Exchange from ‘OFF’ the Exchange in the current commercial networks. Most of these doctors have found themselves listed as participating without even written notification from the insurance company. This is largely due to an ‘all products clause’ in a contract signed, many years ago. Others find themselves listed in newly created insurance companies utilizing ‘rental networks’ such as entities known as MagnaCare or MultiPlan. The fees being proposed simply

cannot allow the physician's business to remain solvent. Again, what good could come of this to society, if another physician is forced to close the office doors forever?

The 90-Day "Grace Period" authorized by CMS will also be a huge problem, and we ask that it be addressed. We are very sympathetic to the problem the Administration was trying to address. Everyone has fallen behind in a bill. Grace periods are a wonderful cushion for such a circumstance. However, the law will create great confusion and potentially unnecessary anger at the physician delivering the care. Once a physician sees a patient and provides the necessary care, the insurance claim is filed. We would then be informed that that patient's insurance is cancelled. Collecting, after the fact, is never easy. It is imperative that the physicians providing services receive the same real-time adjudication offered by the insurance companies to the pharmacies. Without such protection, the account receivables will soar. This will become a great problem trying to meet expenses.

The confluence of all these factors place small practice physicians in an ever-tightening financial vise that threatens to shutter many private physician offices, and with them, an estimated 330,000 jobs in New York State, according to a study from the Medical Society of the State of New York. Undoubtedly, more and more physicians will be forced to close their practices and join large hospital systems in order to continue to deliver care, which will reduce patient choice, reduce competition, and drive up the cost of health care and health insurance. Worse still, many experienced but frustrated physicians have indicated they may simply retire and close their practices, further exacerbating the discussed access to care issues. Again, who will be there to deliver the care for our patients?

New York senior citizens, enrolled in Medicare Advantage Plans recently received notices that their doctors, previously in-network, would now be considered non-participating or out-of-network, even before these same doctors, themselves, were notified of the change by the insurance company. Roughly 2100 physicians were dismissed from Oxford/UHC networks affecting approximately 8,000 Medicare patients. Our seniors deserve better. The insurance companies claim to be reacting to decreased reimbursement from CMS. As physicians, we are urging CMS and Congress to investigate this development. From the insurance industry standpoint, this may be sound for business, but destroyed doctor-patient relationships and the subsequent disruption of the bond the patient feels for their doctor can take a toll on that individual's health and well-being. In fact, one federal court in Connecticut recently imposed a preliminary injunction against United Healthcare from imposing this mass termination.

In closing, by far my greatest concern for the doctor-patient relationship is the limited networks and greater numbers of insured lives. Patients with acute conditions together with their primary care

physicians will lose precious time attempting to locate a qualified specialist and hospital to treat the condition expediently. I thank you, again for the opportunity to present testimony today, and am happy to answer any questions you may have for me.

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**REFERENCES FURNISHED UPON REQUEST**



Committee on Oversight and Government Reform  
Witness Disclosure Requirement – "Truth in Testimony"  
Required by House Rule XI, Clause 2(g)(5)

Name:

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2010. Include the source and amount of each grant or contract.

*None*

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

*I represent myself, a physician, operating as a small business.*

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2010, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

*None*

I certify that the above information is true and correct.

Signature:

Date:

*Patricia A. McLaughlin, MD*

*12-10-13*