February 7, 2017

VIA EMAIL
Sen. Unterman, Chair of Health and Human Services Committee
Renee.Unterman@senate.ga.gov

Re: Surprise Billing and Consumer Protection Act

Dear Senator Unterman:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. **Together, EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year.** We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

We offer you comments on how to make sure patients are informed about their financial responsibilities for healthcare ahead of time and avoid surprises. Because we represent emergency physicians, we will focus our comments on potential surprises when obtaining emergency services. We will also recommend improvements to SB 8.

The biggest surprise is when the patient receives a large bill and **they learn of the huge surprise gap in their insurance.** Emergency care is an "essential benefit" which is "covered" whether it is provided by in-network or out-of-network doctors. So, patients often are shocked to receive larger-than-expected bills for emergency care. They mistakenly assume the bill is a reflection of the doctor's charges over and above fair reimbursement from the insurance company. Yet, in most instances, the bill is simply a reflection of the patient's out-of-pocket costs related to their deductible, co-insurance or copayment responsibilities, which can be quite high. And the emergency physician is neither aware of these surprise insurance gaps nor in control of limiting them.

Emergency bills can contain other unwelcome surprises like expensive bills for transporting the patient to the hospital in an ambulance or helicopter, the "facility fee" which helps cover the cost of having the hospital's many resources on hand, or a specialist's fee when specialists were consulted. Again, the emergency physician cannot control these surprises.

The emergency physician doesn't even have control over the small portion of the bill that reflects the emergency physician's charges because the insurance company unilaterally decides – in a black box – how much will be paid by the insurance company and how much will be considered the patient's responsibility.

Beyond these surprises, the patient is often left confused when it comes time to pay the bill. The patient is faced with numerous versions of the bill coming from a variety of sources: the insurance company, doctors, hospitals, and transporters. And patients must figure out which bills overlap and which bills reflect fees that have already been covered – or will be covered – by insurance.

We believe the solution is transparency and taking the patient out of the middle. The insurance company is the party with access to all of the relevant information and the one with a contractual relationship with the patient. So, the insurance company should be tasked with educating its beneficiaries on what the deductible, coinsurance, and copayments are and when and how they are applied. The insurance company should be tasked with explaining potential facility, transportation, and specialty fees. They should also answer questions on which provider is in-network and the likely range of costs for certain procedures. And, if the insurance company does not adequately fulfill its responsibilities to inform patients of their coverage – and coverage gaps - the patient should be able to request financial compensation from the insurance company.

We also believe the patient should be taken out of the middle when it comes to the confusing mass of bills that arrive after the emergency. We recommend that the insurance company be required to pay the providers in full. Then, the insurance company should collect the patient's contribution directly from the patient, including any coinsurance, copayments, and deductibles. This way, confusion is virtually eliminated, the patient has only one entity to deal with, and patients will no longer be confused and think a bill reflects overcharges by physicians when, in fact, it represents surprise gaps in insurance.

We recommend that you encourage transparency with regard to how insurance companies reimburse physicians. We urge you to fix the problem that reimbursement rates are developed in secret and unilaterally by insurers. We are happy to see that SB 8 includes a definition of "usual and customary (UC)" However, the term inappropriately references the usual and customary "cost" when it is actually referencing the usual and customary "charge." Furthermore, the definition should clarify that the benchmarking charge database that is referenced in the definition must be **transparent and independent (unbiased)**. The FAIR Health database was created after conflicts of interest were discovered in the methods that health insurers were using to underpay providers for out-of-network services. As part of the settlement agreements with health insurance companies, the FAIR Health database was established to bring fairness and transparency to the out-of-network reimbursement system. Even if you choose not to reference the FAIR Health database, the legislative language must make clear that the database will be transparent to payers, providers, and consumers and the data will be controlled and compiled by an entity wholly independent from the insurance industry (and independent form providers for that matter).

We also urge you to add a provision that establishes UC charges (as defined above) as the minimum payment standard for out-of-network services. Connecticut law has had such a standard since July 2016, and many other states are looking at this solution as the most reasonable approach to determining reimbursement. It is important to remember that, if providers are paid fairly by insurance companies under this standard, patients will be responsible for less.

SB 8, on the other hand, currently states that the payment standard is what the insurer determines to be "reasonable." This term is not defined, is inherently ambiguous and impossible to enforce, and is not tied to an independent, transparent database. Tying payment to an independent transparent database would ensure that everyone – insurers, providers and consumers - can access the data, determine when a payment is not in compliance, and easily (and inexpensively) ask that the standard be enforced. Absent such clarity and simplicity, undefined terms like "reasonable" will invite abuse by payers and confusion on the part of all stakeholders, and doctors will have to choose between accepting unreasonable payments or spending a large amount of time and money in dispute resolution.

We urge you to address the real problem – surprise gaps in insurance – in the legislation. The bill should address network adequacy. It should discourage insurers from offering narrow networks. Narrow networks allow insurers to foist the cost of an emergency room visit onto the patient in the guise of an out-of-network deductible (that the patient could not have avoided).

Thank you for considering our comments. If you have any questions, please do not hesitate to contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org.

Sincerely,

Emergency Department Practice Management Association (EDPMA)
8400 Westpark Drive, 2nd Floor
McLean, VA 22102
Phone: (703) 610-9033
Email: emundinger@edpma.org

American College of Emergency Physicians (ACEP)
4950 W. Royal Lane
Irving, TX 75063-2524
Phone: (972) 550-0911x3204
Email: hmonroe@acep.org

cc: Members of the Georgia Senate Health and Human Services Committee