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Testimony before Senate Health and Human Services Committee Re SB 8

Thank you Madam Chair and esteemed committee members for allowing me to speak about Senate Bill 8 on behalf of the Georgia College of Emergency Physicians on this most important topic for our patients and for the Emergency Departments of Georgia’s hospitals- the health care Safety Net for our state.

I am Dr. Chip Pettigrew, an emergency physician who has dedicated my career to serving emergency patients in Georgia. I am an active member of the American College of Emergency Physicians, which represents over 31,000 emergency physicians across the USA who evaluate and treat approximately 150,000,000 patients in our country’s hospital Emergency Departments each year. I am a long-standing member on the ACEP Council and the ACEP Reimbursement Committee.

I am also a Past President of the Georgia College of Emergency Physicians, a professional association of over 800 emergency physicians in Georgia who are dedicated to providing the best care for our citizens whenever they need us. Georgia’s emergency physicians continuously staff the Emergency Departments of our state’s hospitals 24/7/365, providing timely, expert and critically needed care to the nearly 4,000,000 patients per year who present to our EDs, and without any regard to their ability to pay. We are the only immediately accessible Safety Net for all of Georgia’s citizens’ health care needs.

I would like to offer some background information on out-of-network issues, some constructive criticisms of this bill, and some sincere advice on resolving the out-of-network balance billing issue for emergency services.

The underlying problem in the out-of-network issue isn’t “surprise bills,” it’s “surprise gaps in insurance coverage.” The out-of-network crisis was created by the health insurance industry for their profit, but it has resulted in a financial crisis for health insurance plan enrollees… our patients. According to the Past President of the AMA, Dr. Steven Stack, unanticipated out-of-network medical costs are a result “of the way health insurers price their products, organize their provider networks, and interact with non-contracted physicians.”

Over the past few years, insurers have rapidly accelerated the construction of narrow networks in order to maximize the profits for their health care products. Health plans pay more of a patient’s bill for in-network care, so insurers are pushing more and more of their enrollees into out-of-network care situations. Out-of-network care results in the insurer paying little to nothing for the care provided, forcing their enrollees to pay for the majority of the care provided to them. The smaller the network of physicians, the more likely the enrollee will receive a bill for out-of-network care, thus saving the insurance plan money but resulting in a larger balance bill for the patient. Narrow networks have resulted in many of plan enrollees having not only an insufficient in-network physicians for their on-going needs, but also a significant lack of in-network physicians for their emergency needs. Physicians are not being allowed into networks because insurers don’t want to pay truly fair or customary rates (now that they can no longer manipulate the databases upon which they previously relied for coverage and payment determinations).

No one can schedule where they will be in an emergency medical situation and patients should not be financially penalized by their insurance companies for having emergencies. Georgia has the second highest percent of narrow network policies in the USA. The lack of timely and appropriate heath care due to narrow networks and high deductible plans has allowed insurers to indirectly dissuade Georgians from obtaining timely and appropriate in-network health care services, and it has also allowed insurers to deny coverage or pay only a paltry sum for out-of-network services- leaving their enrollees/our patients on the hook for a balance bill for those services rendered. Since the implementation of the ACA, there have been significant reductions in insurance payments for emergency care, as much as 70 percent, per ACEP data.

An analysis of EOB data from just three commercial health insurance carriers for 2013 was submitted to CMS in 2014 showing that $642,000,000 in previously covered emergency services payments for out-of-network services had now become the patients’ responsibility due to lowered allowed amounts. Adding the remainder of insurance plans to this equation would undoubtedly show that billions of dollars have been transferred to patient responsibility by insurers since 2010. This theft of enrollee benefits is an unconscionable reality.

* Though it is the insurers who are cost-shifting massive amounts to their enrollees,
* It is the insurers that are not negotiating fairly for in-network status,
* It is the insurers who are choosing to abuse the federal EMTALA mandate, nonetheless
* It is the insurers who are labeling physicians as being the ones at fault.

Health care insurance companies are taking advantage of the federal government’s EMTALA mandate. This federal law requires all persons presenting to hospital Emergency Departments to be seen and stabilized to the fullest capability of that facility, regardless of the person’s payer status or even their ability to pay for these essential emergency services. EMTALA gives the insurance industry the upper hand and allows them to exploit their payment for services. While emergency physicians, and those other physician specialists who provide backup subspecialty care to emergency patients when necessary, have to see all patients, insurers are scheming to get out of paying fairly for any of their enrollees. Not fairly negotiating in-network status for their enrollees to be seen in Emergency Departments, insurers remain confident that their enrollees will get the best care possible and, after-the-fact, these insurers will offer the treating physicians inadequate sums for such care and force us to bill our patients for any balances due.

Insurers are engaging in a PR battle to paint physicians as the culprits for the balance billing crisis even though it is the insurers’ own policies which have *surprise insurance coverage gaps*… gaps which do not cover their enrollees for necessary services even though monthly premium payments are being sacrificially made by their enrollees month-by-month. Due to the construction of narrow networks, the sale of high deductible policies, and the unintelligible nature of lengthy, legalese-ridden policies, Georgians are afraid to access appropriate health care. A 2015 ACEP survey of emergency physicians showed that most of us have recently seen patients who have delayed seeking medical care because of high out-of-pocket expenses such as high deductibles, high coinsurance, and high copayment responsibilities. Many of these insurance enrollees then show up in Emergence Departments with conditions that should have been taken care of sooner. Furthermore, when emergency patients receive bills, because of their lack of understanding of their complex insurance policies, they often confuse large bills with out-of-network status when it is frequently their insurance plan’s huge deductibles that are the main source of their financial frustrations. An expert in emergency medicine billing consulting reported in 2016 that out-of-network emergency physician bills are “generally in the $200 range with some as high as $500,” while patient deductibles are now in the thousands of dollars, often such a huge sum as to be unaffordable. Patients sign up for these “affordable” plans while hoping that they will never have to face a major medical issue because they cannot afford to pay for both premiums and deductibles.

Surveys show that emergency physicians prefer to be in-network with health insurance plans, but they cannot if they are not offered a fair contract. Balance billing would not exist if physicians were offered a fair payment for their services. We emergency physicians do not want to balance bill our patients. Emergency physicians want to help our patients to get out of their financial crises. Emergency physicians want fair coverage for plan enrollees for the premiums that they have already paid, and emergency physicians want fair payment for services that we have already rendered.

The Georgia College of Emergency Physicians and the Medical Association of Georgia have, over a carefully undertaken two-year process, constructed an uncomplicated and fair solution to this out-of-network crisis regarding insurance coverage for our patients’ emergency services. We have proposed, in subcommittees and in meetings with legislators, the following two items. Similar proposals have been successfully enacted in both NY and CT.

MAG/GCEP Legislative Proposal for Out-of-Network Emergency Services

1. In the event a covered person receives emergency medical care by a nonparticipating provider, the nonparticipating provider may bill the carrier directly and the carrier shall directly pay, as coded and with first dollar coverage, the nonparticipating provider for the emergency medical care rendered to the covered person *at the lesser* of the following amounts:
   1. The providers’ actual charges; or
   2. The current 80th percentile of all charges for the same particular emergency medical care, in similar facilities, performed by emergency medical care providers, as reported by a non-profit organization which maintains a comprehensive, transparent, independent benchmarking database of actual charges and which is not affiliated with any health carrier; such as FAIR Health.
2. “Emergency medical care” means emergency services provided after the onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical or surgical attention could be reasonably expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, and for the first 24 hours after the covered person’s emergency condition has stabilized, whether the emergency services and services after stabilization occur in an Emergency Department or not.

For consideration of the above statute, patients would no longer be balance billed for any out-of-network emergency services other than for their contracted deductibles and other patient responsibilities. Effectively, this solution makes every emergency service in Georgia covered at a predetermined range of values which excludes seemingly excessive charges (the top 20%) and enrollees (our patients) would no longer be subjected to uncovered out-of-network balance bills.

As it is the insurers who have designed innumerable and difficult-to-understand health care policies and neither the enrollees nor the physicians understand all of the intricacies of these many policies, it will be the insurer’s responsibility to pay the physicians directly in the amount of *the lesser* of the actual charge or the minimum benefit standard. The insurer shall be able to then educate their enrollees on the plan’s specific cost sharing and financial responsibilities, and the insurer shall collect from their enrollees the contracted amounts due as per the various deductibles, copays, coinsurances and any other patient responsibilities as designed by the insurance companies into their contracts. After all, *the insurance contract is between the insurance company and its enrollees, and not between physicians and their patients. Physicians should not be held responsible to explain the plan’s intricacies of coverages and payment responsibilites, nor should we be forced into the role of acting as the insurers’ agents as enforcers for the plan’s financial obligations.*

SB 8 (current version as of 2/3/2017) comments:

1. This bill only includes a portion of the regularly performed services and procedures which are done in the hospital Emergency Department. Many common procedures will fall outside the emergency services exemption and be sent to dispute resolution. We recommend that, as in the MAG/GCEP model legislation, all emergency services performed under the EMTALA mandate be covered and paid as described above.

2. Arbitrarily fixing the current maximum price for services at $600 is unrealistic in light of the many intensive and critical services which are performed in Emergency Departments. Putting caps on out-of-network charges gives insurers the upper hand in negotiations. Insurers will have absolutely no incentive to negotiate in-network rates when rates are artificially kept low by force of law. Again, we recommend a minimum benefit standard as noted previously.

3. Limiting the eventual maximum amount to an eventual $1200 after many years of inflation is also unrealistic. Even with currently low inflation rates, costs will surpass 200% of today’s costs within a decade or two. Legislators will not want to have to revisit this provision at some later date.

4. The term “costs” is frequently used in this bill when referring to a database. There is not independent and verifiably true database of costs. There are databases of usual and customary *charges*. The only independent, robust, accessible and transparent database of charges, per the NORC consultant to CMS, is FAIR Heath. The FAIR Health database is already used by Georgia for determining the Worker’s Compensation fee schedule.

5. Instructing insurers to reimburse at a “reasonable” rate is a nonspecific instruction that can lead to multiple interpretations of what is or isn’t reasonable. Insurers are, buy business practice, inclined to pay as little as possible. Using an independent database to determine usual, customary and reasonable is the only way to ensure that “reasonable” is truly reasonable.

6. Neither patients nor providers can afford to participate in a dispute resolution process. Patients and physicians need to be going about the business of their daily lives. They neither have nor can afford legions of employees representing their interests in any dispute resolution processes. Only insurers will be able to regularly attend these time and resource consuming meetings. Dispute resolution processes must be avoided or patients and physicians will lose via a war of attrition. Carefully crafted minimum benefit standards will allow dispute resolution processes to be avoided.

7. The Out of Network Reimbursement Workgroup will be tasked with reviewing massive amounts of data and methodologies. This workgroup will be populated with volunteer individuals, some of whom have no concept of the economics of health care delivery. The scope of this workgroup and its makeup doom it to failure.

8. Methodologies mentioned for the workgroup to consider include Medicare and Medicaid. These government programs were never designed to represent fair payment for healthcare services. Most physicians in Georgia do not accept Medicaid patients because of the incredibly low reimbursement rates. Many physicians in Georgia do not accept Medicare, either. Medicare rates were never intended to be used as a payment standard for physician services. The federal government readily admits this. The same statement also applies to Medicaid. Since the inception of the Medicare Physician Fee Schedule in 1992, the government reimbursement rates (already low at its inception with then usual and customary charges averaging 200-300% of the Medicare rates) have fallen further and further behind. Comparing the 1992 vs 2016 Medicare Fee Schedules with the CPI, Medicare rates are now less than 20% of what they originally were. So, the comparable multiple of Medicare to bring its value to what it was in 1992 would be a multiple of 5.28X Medicare. Using such artificially low rates, as noted previously, will take away any incentive for insurers to negotiate fairly with physicians for in-network status. It will be much cheaper for insurers to keep physicians out-of-network. Using an independent database of usual and customary charges avoids comparing actual marketplace medical economics with contrived, political decisions based merely on budgetary constraints.

In summary

* SB 8 does not address the cause of out-of-network balance billing- narrow networks and expensive health care plans which have massive surprise coverage gaps.
* SB 8 does not provide for fair payment for physician services mandated by EMTALA, while it gives the insurers the upper hand via mandating inadequate payment for those services and removing any incentive for insurers to contract via fair negotiations for in-network status.
* SB 8 unnecessarily risks economic collapse of Georgia’s health care Safety Net.
* If the provisions of this bill are enacted into law, most rural hospital Emergency Departments and many other Emergency Departments across the state will find that emergency physician staffing groups will no longer participate in staffing our hospitals with emergency physicians, and most independent emergency physician groups will not longer be able to recruit or retain qualified emergency physicians.

My best advice for solving the out-of-network crisis in Georgia would be

* Focus state legislation on a fair minimum benefit standard of payment for emergency services provided under the federal EMTALA mandate, and
* Inclusion of all emergency services up to the first 24 hours of stabilization for such payment.
* Having the insurers pay the physician providers of these services directly and in full, while educating their enrollees and billing them for their various deductibles and other patient responsibilities, would truly get the patients out of the middle and end this crisis.

I have attached several supporting and explanatory documents for your review. The attachments provide further background information on, and explanation of, the topics discussed in my testimony. I will be happy to answer any questions that you may have, now or in the future.

Thank you for allowing me to meet with you today and provide my perspective on out-of-network balance billing, its true causes, and our proposed solutions. I have endeavored to discuss not only fair solutions, but also to encourage the protection of Georgia’s EDs, the health care Safety Net for our citizens. Anything less than a fair solution to this problem will put Georgia’s citizens, and our Safety Net, at risk of financial collapse. We rely on fair payment to keep our doors open. Our patients need us and they deserve fair coverage from the insurance industry instead of surprise insurance gaps.

Attachments:

1. Response to request from Sen. Unterman re averaging Medicaid, Medicare and FAIR Health, January 12, 2017
2. Beckers Hospital Review, December 9, 2016: American Healthcare’s one Constant in a Sea of Change: Emergency Medicine
3. ACEP Release, January 18, 2017: Health Insurance Companies are the Culprit
4. Health Plans Cheat Enrollees of $Billions in Benefits for Emergency Care, Myles Riner, June 4, 2014
5. End the Surprise Insurance Gap: PFC Recommends FAIR Health
6. FAIR Health Mission, History and Mandate
7. Comparison of Health Care Databases, Optum360, FAIR Health, and HCCI
8. Reasons Why Emergency Physicians Must Maintain Current Charges to Commercial Payers
9. Consensus Principles on Insurance Coverage for Out-of-Network Care Provided by Hospital-Based Physicians, Physicians for Fair Coverage
10. Physicians for Fair Coverage Poster