



Testimony by Sharon Barrett On March 17, 2015

SB 808 AN ACT CONCERNING THE ESTABLISHMENT OF A DISPUTE RESOLUTION PROCESS FOR SURPRISE BILLS AND BILLS FOR EMERGENCY SERVICES.

Good Afternoon Senator Crisco, Rep Megna and other distinguished members of the Insurance and Real Estate Committee. I am Sharon Barrett, MD, a board certified dermatologist practicing in Connecticut. I am here to represent the CSMS physicians and physicians in training and the over 1000 physicians in the medical specialties of Dermatology, Ophthalmology, Otolaryngology and Urology. On behalf of this group of dedicated physicians, we thank this committee for raising an Act Concerning the Establishment of Dispute Resolution Process for Surprise Bills and Bills for Emergency Services. We have participated in testifying on a number of bills in public health this year some of which include the subject of surprise bills for emergency services. This subject has received considerable attention for several reasons.

First, patients have the duty to pay for larger amounts of their healthcare because of the high deductibles many plans have adopted and forced on consumers. Second, insurer decisions and consolidation in the provider market have created a growing pool of consumers who have lost the ability to see their physicians independently. Many physicians have been forced to integrate into a hospital based system, where facility fees are an unwelcome part of the healthcare cost equation. Third, led by United Healthcare, insurers have been narrowing their networks, throwing providers off of plans with limited, if any, notification to patients. This has led to a patchwork of network and non-network physicians providing services at any given location or institution. Sometimes, a hospital or other facility is "in network", but none of its providers are. It gets further complicated by the number of benefit plans one insurer can offer and the provider is not aware of which one he/she is in or out. Patients who seek care at these facilities may require urgent or emergent services which often falls to whatever provider is on duty at that time. The provider performs the necessary care, without regard to the patient's insurance status. That service is then billed, as is appropriate. If the provider is not in-network, the insurers will often insist on a lesser payment, or no payment, with the remainder to be made up by the patient. This uncovered care, appropriately rendered and billed, can lead to

significant out of pocket costs for patients. Concern over these “surprise” costs has, fortunately, brought about your effort to ameliorate the issue.

Connecticut Physicians are also concerned. We have consistently proposed and supported legislation that would reduce the Certificate of Need burden to allow more service sites that do not charge hidden facility fees. We have repeatedly asked that some form of collective bargaining power be granted to physicians to allow them to negotiate better protocols and policies with insurers to prevent these kinds of surprises. Unfortunately, these have not yet come to fruition. This bill offers a mechanism for addressing problems after they occur, but the solution should lie in heading off surprises before they arise. It can be very difficult, even for experienced providers used to dealing with insurers and their websites, to accurately determine what and who is covered by any given plan, or even which plan the patient actually is on. Even when a list of providers can be found, it often is aggregated over several plans, or represents a global list, without clear specificity of in which networks a given provider participates. Further, as we saw with United HealthCare, the list is often simply wrong, containing the names of providers who are no longer in network. Making a referring provider responsible for accurate determination of a referral’s network status will only result in a disclaimer being offered every time, to avoid surprises. Much better would be to require more transparency and accuracy on the part of insurers regarding their network structures and participants. A referring provider could then provide a list of potential referrals, and the insurer would be responsible for indicating the network status of those providers within a reasonable timeframe. If they fail to do so, they would be responsible for all fees as if the provider chosen for the service was in network.

We would also suggest the following protocols for resolution of disputes involving emergency care:

- For emergency services provided to an insured by a non-participating health care center that bills the health plan, the plan must pay a reasonable amount and ensure that the insured will incur no greater out-of-pocket costs for the services than he or she would have incurred if the health care center was participating. The health care center or plan may submit a dispute to an independent dispute resolution entity, which must then make a binding determination within 30 days and select either the plan’s payment or the health care center’s fee. (This should encourage health care centers to bill more reasonably so the dispute resolution entity will select its reasonable fee.) The health plan should pay the fee to the dispute resolution entity. It will be an incentive to pay the bill reasonably the first time.
- For emergency services that are provided to an uninsured by a health care center, such uninsured person may submit a dispute regarding a fee to an independent dispute resolution entity upon approval of the Office of HealthCare Access? The patient need not pay the health care center’s fee in order to be eligible to submit the dispute for such review. The independent dispute resolution entity will then make a binding determination of a reasonable fee for the service. The health care center should pay the fee. It will be an incentive to bill reasonably.

Again, thank you for addressing this important and pressing issue for the benefit of our patients.