

February 21, 2020

**H.B. No. 5053 (RAISED) AN ACT CONCERNING THE REDUCTION OF ECONOMIC DAMAGES IN A PERSONAL INJURY OR WRONGFUL DEATH ACTION FOR COLLATERAL SOURCE PAYMENTS MADE ON BEHALF OF A CLAIMANT.**

Good Afternoon, Senator Winfield, Kissel, Representatives Stafstrom, Rebimbas and other distinguished members of the Judiciary Committee. My name is Phil Kerr, M.D. and I am here today representing approximately 1200 physicians in the medical specialty organizations of Dermatology, Ophthalmology, Otolaryngology, Urology and Orthopaedics in strong support of HB5053. I am here to offer insight into the complexities of medical insurance billing and to provide perspective as to why HB5053 is necessary to rectify a “windfall” situation with regard to a plaintiff’s economic damage calculations in personal injury cases.

Last year my colleague, and Past President of the CT Dermatology Society, testified on this important bill explaining the injustice of economic damages based on a fictitious “billable face amount” rather than on the actually paid reimbursement amount. Medical billing is difficult and at times quite confusing, and I present here some important facts that this committee should know.

The amount “billed” by a physician is not what the physician is actually paid by an insurer. In fact, a physician gets paid only what the insurance company fee schedule allows for any given procedure or service, regardless of the amount which is submitted on a bill. Per provider/insurer contracts, the physician cannot “balance bill” a patient for the difference between the billed amount and the actually paid amounts.

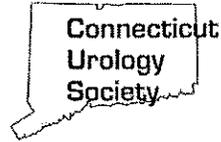
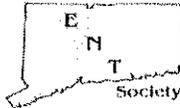
As an example, last year I submitted a bill for the removal of a skin lesion for \$2000, but the amount I was paid was based solely on the fee schedule for that code for that carrier. In this case I was paid \$100. The difference of \$1900 was written off and will never be collected, or charged to the patient.

So why are there such discrepancies between the billed amount and the actual reimbursement? Our computer billing systems use one billable amount for each code for each insurer, although in reality there are often hundreds of unique individual plans offered even by a single insurer, and each one may reimburse different amounts (even within the same company) based on their unique fee schedules.

We are actually forced to submit a higher “billed” amount than the expected reimbursement amount, because if we submit a bill that is less than the amount that an insurer reimburses, we get paid a reduced reimbursement (less than the contracted amount on the fee schedule)!

Some would argue that physicians should simply bill appropriate fair market fees and not use one “inflated” rate, but this is not feasible. In order to determine fair market value of a service, physicians would have to discuss amongst each other their fees, but this is considered a violation of Anti-trust laws which explicitly prohibit such communication. Reimbursement rates can also change even during a contract term, and it becomes difficult, if not nearly impossible, to always keep track of every insurers’ changes. Thus, a common billed rate – which is appropriate to cover all billing conditions – is the providers’ best and only current solution.

Individual providers have little to no say in the fee schedule rates, having to simply accept the insurers’ proposed rate (or leave it). Add to this the complexity that some insurers pay higher amounts than others, with Medicare and Medicaid paying reimbursement rates which can be below, and often far below, fair market rates. In these cases, the calculated discrepancy between the “billed” amount and our reimbursed amounts is even larger creating an illusion that we are



“inflating” our rates. Placing any onus on the provider for the higher and inaccurate “billed” amount is not fair or reasonable.

When one considers all the variables, medical billing is difficult and confusing. The ever growing “high deductible plans” have only further added to this complexity and has dramatically increased the challenges and burdens placed upon individual practices.

In closing, and to restate our testimony in 2019, economic damages should not be based on medical “billed” amounts, but should instead be based on the fee schedule that specifies the actual reimbursed cost of the services rendered. Plaintiffs should not be eligible to receive a windfall because of the flaws of our current billing methods, methods which are designed to appropriately reflect the rules of the various plans and insurers.

Thank you for considering support of HB5053.

Thank you.

**Testimony  
available for  
public review in**

**Judiciary Committee  
Room 2500**