Balance Billing and How it will Impact Florida

HB 221: Health Insurance Coverage for Emergency Services
GENERAL BILL by Trujillo ; (CO-INTRODUCERS) Stark

SB 1442: Out-of-Network Health Insurance Coverage (similar to HB 221)
GENERAL BILL by Garcia

The proposed legislation impacts physician reimbursement in emergency departments, limiting the amount a physician can collect to the amount arbitrarily reimbursed by insurance companies. Though coined as a ban on "balance billing," the legislation has a chilling effect in a state with a debunk provider dispute program and no third-party claims data base for payment transparency.

Setting the Facts Straight

Emergency physicians are the **ONLY** specialists who see every patient, regardless of insurance status or ability to pay – 24 hours a day, 7 days a week and 365 days per year.

The emergency physician sees an **average of $138,000 per physician in uncompensated care yearly** and is the Safety Net for all Florida citizens, including vulnerable uninsured, Medicare, Medicaid, and Pediatric patients.

Emergency Physician Out-of-Network (OON) Charges:

Average Emergency Physician OON Charge is*

$679

Insurers' typical average payment is*

$307

Average patient payment of their $372 deductible, co-pay and balance bill is*

$49

The 80th percentile charge for highest acuity EM visit is**

$950

* Sample of 10% of FL ED visits, 2014-2015

**Reference: FAIRHealthConsumer.org
CPT 99285 ZIP: 320XX

Balance Billing results from the unwillingness of insurers to contract for adequate payment for providers, which occurs for only about 12% of insured Floridians.

Insurers are cutting their costs by paying providers less and raising deductibles on patients, increasing the burden on consumers but raising insurers' profits.

Customary Reimbursement of Emergency Provider Services

Physicians set charges based on the cost of recruiting and retaining qualified providers, providing for uncompensated and undercompensated care, standby costs for surge capacity, medical malpractice insurance costs, among other factors. Physicians may allow for some discounts to preferred contracted insurers. National and state databases, such as FAIR Health, show aggregate and median charges per zip code for billions of provider charges.

Insurers vary widely in how they reimburse OON charges. The range of reimbursement varies from zero to a low percentage of Medicare allowables to full charges.

In a PPO, the consumer does not have indemnity coverage (as they would in a HMO or Medicare), but an arrangement that allows insurer to pay their own determination of the "Maximum Allowable Charge" or a percentage thereof.

- Consumers are buying a **flawed product**, and **narrow networks** makes this worse.
- Insurances are selling "in-network" hospitals, while often **NOT** negotiating with physicians who staff those hospitals.
- Allowing insurers to unilaterally determine "allowable" reimbursement lacks transparency, encourages manipulation and is not based on the costs of providing care by the physicians.
- This will lead to **downward market forces** that will hinder EM physicians from negotiating fair in-network rates, which they do now **88%** of the time.

Four Out of Five "Big Insurers" have been sued for illegally manipulating UCR

Underpayment of Emergency Physicians leads to balance bills.

Breaking Down Your Healthcare Insurance Plan/PPO By the Numbers

What you expect when you purchase PPO OON coverage (at a premium):

- Indemnity-style coverage (like HMO and Medicare):
- True 80/20 coverage (or alternate % purchased)

$1,000 charge
PPO Pays 80% ⇨ **$800**
You pay 20% ⇨ **$200**

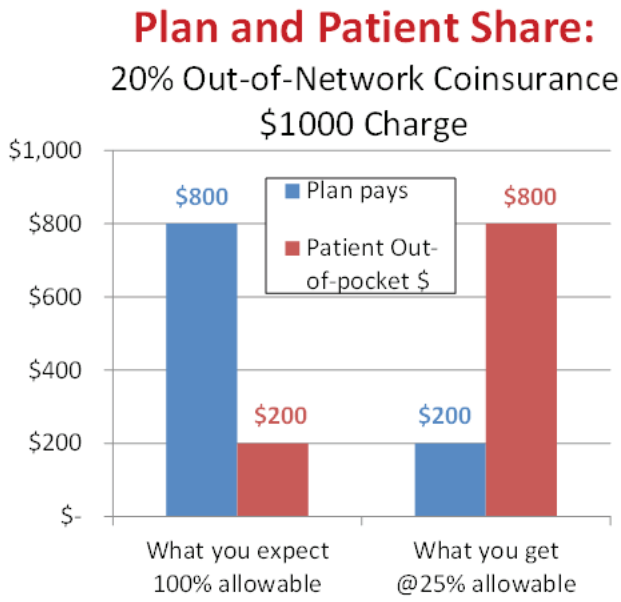
NO BALANCE BILL

What you actually get:

- PPO sets arbitrary and variable "allowable"
- No transparency
- Allowables as low as **25% of charges**

$1,000 charge
PPO pays 80% of $250 ⇨ **$200**
You pay 20% of allowable **plus** balance bill ⇨ **$800**

Insurer charges more for OON coverage, but shifts cost of care to the patient.



FCEP/FMA's Proposed Resolution Benefitting All

Couple a ban on balance billing of consumers with a requirement for adequate payment of providers by insurers:

- Expand exisiting HMO law to require payment of usual and customary charges for OON providers.
- Provide transparency by defining UCR with a 3rd party, nonprofit public consumer database like FairHealth.org.
- Require insurers to pay EM providers and collect the co-pay and deductibles required by their plan designs from consumers directly – removing the onus on EM physicians to act as bill collectors on behalf of insurers, or pay on behalf of patients.

Dispute Resolution

Florida's current system (MAXIMUS) is rarely used and ineffective. Illinois' arbitration system is not specifically set up for billing disputes, and is not being used by providers due to prohibitive costs.

Ineffective dispute resolution forces providers to accept arbitrary insurance payments, leading to underpayent, physician shortages and disruption of the healthcare safety net. Other states have established more effective dispute resolution processes.

New York arbitration process is especially well defined:

- Uses arbiters knowledgable about health care economics.
- Criteria for settling disputes well defined, using transparent third-party verfiable data.