



Physicians Caring for Texans

## **Texas Medical Association Testimony Senate State Affairs Committee**

**Interim Charge #7**

**September 15, 2014**

**Presented by: Patrick Carter, M.D.**

Good morning, Chairman Estes and members of the committee. My name is Patrick Carter and I am a family physician with the multi-specialty physician group practice, Kelsey-Seybold Clinic in Houston. Kelsey-Seybold Clinic is the first accountable care organization accredited by the National Committee for Quality Assurance. I am here before you today representing the Texas Medical Association (TMA) and more than 48,000 physicians and medical student members. I would like to thank Chairman Estes and committee members for the opportunity to testify about the impact and implementation of Senate Bill 1731(R-80th).

### Background

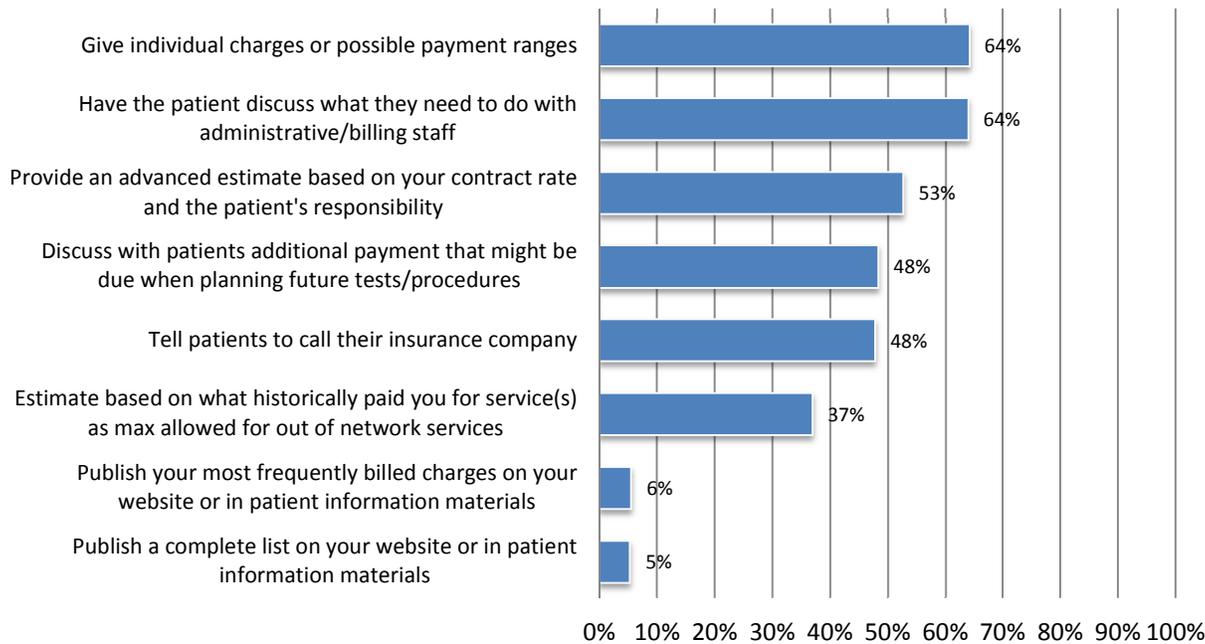
The passage of SB 1731 in 2007 provided patients, both insured and uninsured, the opportunity to obtain health care estimates from hospitals, physicians and health plans. The legislation realized that there are two groups of patients that will access services: the insured patient and the uninsured patient. The bill specifically delineated the two. The delineation is necessary because the amount that will be paid out of pocket by the patient differs depending upon the insurance status of the patient. In addition, the bill recognizes that where a patient should seek information about what they will owe, is dependent upon the patient's insured/uninsured status. Attached you will find a table of the requirements found in SB 1731 for physicians, hospitals and health plans along with the oversight requirements of their respective regulatory agencies. (Attachment #1).

SB 1731, which has been law for 7 years, continues to be a useful tool for Texas consumers to obtain information regarding their out-of-pocket exposure for health care services. Texas physicians supported the passage of SB 1731 in 2007 and continue to provide estimates upon request. A recent 2014 TMA Physician Survey has provided insight into how physicians communicate with patients about their fees.

Even though SB 1731 does not require physicians to provide estimates for insured patients, fifty three percent of physicians surveyed provide an advance estimate based on the physician's contract rate and the patient's responsibility, such as copays, deductibles and co-insurance. It is important to note that estimate amounts will vary from patient to patient, and can vary for the same patient due to what time in the coverage year services are sought and provided. Even more interesting is the fact that 11% of all physicians post charges for all or some of the services they offer.

(See survey results below – note, physicians could choose from one or MORE of the disclosure methods. The percentages show the proportion who chose that *particular* method of disclosure)

## Physician Fee Disclosure



From TMA Physician Survey 2014

### Ongoing Physician Education Regarding SB 1731

Since the passage of SB 1731 in 2007, TMA continues to educate physicians and their office staff regarding the required disclosure of certain information to patients under this law.

Since 2007 TMA has developed and provided:

- An information page on our website that outlined the physician estimate and disclosure responsibilities under SB 1731 (Attachment 2);
- Multiple presentations to various organized professional groups, such as office managers, IPAs, practice administrator groups and groups for those who work in the health care field;
- A program called “Billing Cures” - Since 2011 this individualized approach has benefitted more than 500 physician practices in counties throughout Texas who request a more pointed discussion about their practice operations; and
- Information through the TMA Knowledge Center regarding billing disclosure requirements to a quarter (>500) of the more than 2,000 billing and collections inquiries received from 2010 to the present. (Attachment 3)
- TMA’s publication *Policy and Procedures: A Guide for Medical Practices* contains information and sample policies required in SB 1731 to help physicians comply with state and federal billing rules. Since 2011, TMA has distributed over 1,000 copies of the *Guide* to physician offices around the state.

### Medical Price Transparency

Physician charge information is already available over the internet through numerous sources. Internet sites, such as FairHealth and Health Care Bluebook, provide patients with charge information that is characterized as “a fair price to pay for a service or product” when paying cash at the time of treatment. For their insured lives, many insurers offer charge as well as payment information via a “cost estimator” program on the insurer

website. One of Texas' largest carriers literally has "an app for that" which can provide estimates depending on a number of variables such as the location for the proposed procedure.

The March 2013 TIME magazine article by Steven Brill, "*Why Medical Bills Are Killing Us*" captured the attention of the public, national news media, Congress and many state legislatures. Senators Max Baucus (D-Montana), Chairman of the US Senate Finance Committee and Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, have held committee hearings examining ways to improve transparency and ideas on lowering health care costs in America.

TMA knows there is interest in the business community for "transparency" and there is increasing patient interest in regard to charges as more of the financial cost through high premiums and narrow networks is placed upon them by benefit plan design. As you can tell from the survey we conducted, physicians attempt to meet patients' information needs – and the market demands for transparency - in a variety of ways. However, as there have been proposals for a law mandating disclosures, some of which had the possibility of staggering penalties, TMA began an effort to explore enhancing the current transparency framework established in SB 1731 without adding undue administrative burdens or stifling innovation in how services are delivered.

TMA formed a Core Transparency Workgroup composed of members of the TMA Council on Legislation. Throughout the past year, our core workgroup has been provided articles, legislative language from other states, and position papers from employer, consumer groups and health plans about transparency. The TMA Workgroup has kept its finger on the pulse of how this issue is being perceived by the public at large, legislators, consumer think tanks and employers.

As the policymaking process for the TMA workgroup moved forward, several basic tenets were identified as guardrails for any government intervention in the free market:

1. The disclosure should be billed charges of each provider/facility's most frequently billed services, goods or procedures, not proprietary contract rates or otherwise discounted rates (SB 1731 addresses those estimates already);
2. All licensed, certified, or registered health care professionals, ancillary service providers, and hospitals/ASCs/facilities/free standing ERs, radiology labs, etc; should have the same or similar regulatory burden;
3. The number of services, goods, or procedures to be disclosed should be relevant to what is offered in the marketplace reflecting what physicians and health care providers regularly provide to consumers as well as what those consumers typically inquire about or request. Anything more than that is onerous and offers difficulties for compliance (i.e. a mandate to disclose the charge for services not frequently or rarely provided, etc.);
4. Health care professionals, ancillary service providers, and facilities must be able to retain the ability to adjust their charges as needed (raise or lower);
5. Disclosure requirements need to be flexible to allow health care professionals, ancillary service providers and facilities to express their charges as individual, bundled or both, as applicable and in a manner the complements their business model (value based, insurance based, cash based, or retainer/concierge). Stringent or inflexible approaches may create obstacles for or inadvertently block experiments in health care – such as ACOs;
6. Any infraction should elicit a remedial not punitive approach by government. The intent should be to support transparency. Thus, intervention should be administrative only and should not seek to impose a "black mark" against a health care professional's, ancillary service provider's or facility's licensure; and
7. Health care professionals, ancillary service providers and facilities should receive state anti-trust sanctions when they make their charges available.

### Closing

As the committee considers recommendations on this interim charge, the physicians of Texas ask that you recognize that SB 1731 will continue to provide much needed information to consumers, regardless of insurance status about what their out-of-pocket payment obligations are for health care services. Any legislative considerations should work in concert with SB 1731, not require burdensome or rigid posting requirements and most importantly, be beneficial and useful to consumers. Thank you for the opportunity to testify and provide our perspective. I will be happy to answer any questions.

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