Opposing testimony of

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HB5247 AN ACT CONCERNING EXPLANATIONS OF BENEFITS.

Good afternoon Senators Lesser, Kelly, Representatives Scanlon, and Pavalock-DAmato, and distinguished members of the Insurance and Real Estate Committee. I am Joseph Wagner, M.D., a board certified urologist and immediate past president of the CT Urology Society. I come before you today on behalf of the physicians and the physicians-in-training who are members of the above mentioned medical societies, representing over 1000 Connecticut physicians, and we strongly oppose HB5247.

HB5247 seeks to diminish transparency and to permit insurers loopholes to provide (1) No Explanation of Benefits (EOB) or (2) Minimal Explanation of Benefits. It further calls into question the rights of providers of care to receive Explanations of Benefits.

Thanks to Connecticut's strong insurance statutes pertaining to EOB, patients gain access in three key areas: **transparency in billing, insurance fraud protection** and **promotion of healthcare literacy**. Line 32 reads: *"(i) Not issue explanations of benefits concerning covered benefits provided to such consumer"*. Why would we seek to dilute and jeopardize our current system?

Rather than scaling back these benefits, we should seek legislation in 2020 to further improve insurer's requirements for transparency and to continue to build upon the medical literacy Connecticut has already established. HB5247 if passed would degrade our system by diminishing transparency, reducing patients' ability to detect and prevent insurance fraud, and threatening our gains in healthcare literacy.

It would also jeopardize the rights of providers of care to receive Explanation of Benefits. Lines 33-34 note the following option: *"(ii)Issue explanations of benefits concerning covered benefits provided to such consumer solely to such consumer"*.

Providers are struggling in a system where explanations of reimbursements and rejected or reduced claims are already confusing and difficult to grasp. Eliminating an EOB for provider business offices only promises greater confusion and stress trying to understand payments and denials, and will add a terrible burden to office staff trying to reconcile patient accounts. This is an ill-conceived option.

HB5247 if passed will allow insurers opportunities to NOT provide a thorough and clear explanation of payments, and to confuse rather than clarify patient options. Patients need more information regarding their healthcare expenditures to help them understand the nature of the medical services received, the discrepancies between provider charges and payer payments, and better accountability and transparency.

In closing the statement of purpose of HB5247 should be to:

To require health insurers that provide health insurance policies in this state to **always** issue explanations of benefits to consumers and providers, and disclose information concerning explanations of benefits to consumers and providers. It is essential that we maintain **transparency in billing, insurance fraud protection** and **promotion of healthcare literacy** for the citizens of Connecticut.

We ask this committee to respectfully reject HB 5247

Because Healthcare billing is so complex we have attached a reference on some of the components on an Explanation of Benefit

A typical EOB has the following information, although the way it is displayed may vary from one insurance plan to another:

- **Patient:** The name of the person who received the service.
- **Insured ID Number:** The identification number assigned to the patient by his/her insurance company. This should match the number on the patient's insurance card.
- **Claim Number:** The number that identifies, or refers to the claim that either the patient or the health provider submitted to the insurance company.
- **Provider:** The name of the provider who performed the services. This may be the name of a doctor, a laboratory, a hospital, or other healthcare providers.
- **Type of Service:** A code and a brief description of the health-related service the patient received from the provider.
- **Date of Service:** The beginning and end dates of the health-related service the patient received from the provider. If the claim is for a doctor visit, the beginning and end dates will be the same.
- **Charge (Also Known as Billed Charges):** The amount the provider billed the patient's insurance company for the service.
- **Not Covered Amount:** The amount of money that the patient's insurance company did not pay his/her provider. Next to this amount there may be a code that gives the reason the doctor was not paid a certain amount. A limited and usually canned description of these codes is usually found at the bottom of the EOB, on the back of your EOB or in a note attached to your EOB. Physicians believe these explanations are not adequate and need to be better tailored to the individual receiving the care. Insurers generally negotiate take it or leave it payment rates with doctors, so the amount that ends up being paid (including the portions paid by the insurer and the patient) is typically less than the amount the provider bills. The difference is indicated in some way on the EOB, with either an amount not covered, or a total covered amount that is lower than the billed charge.
- **Amount the Health Plan Paid:** This is the amount that the patient's health plan actually paid for the services he/she received. Even if they have met their out-of-pocket requirements for the year already and do not have to pay a portion of the bill, the amount the health plan pays is likely a smaller amount than the medical provider billed.
- **Total Patient Cost:** The amount of money the patient owes as their share of the bill. This amount depends on their health plan's out-of-pocket requirements, such as an annual deductible, copayments, and coinsurance. Many plans today have high deductibles requiring the patient to be responsible for the covered payment amount.