Good morning. My name is Todd Williamson. I am a neurologist in private practice in Gwinnett County. I appreciate the opportunity to speak to this committee.

I believe the fundamental questions before us concern payment for medical care and patients having access to the physician of their choice.

Medical care is expensive. It costs lots of money to train doctors and nurses, develop and test medications, run hospitals, maintain medical equipment, run a physician’s office, and cover professional liability costs for all of these entities. Americans, by choice, spend lots of money on medical care because their health is important to them. Good medical outcomes allow patients to continue on with their lives and their careers. Restoring a patient to health is rewarding, although it is an expensive endeavor.

Health insurance was created to help individual patients pay for unexpected costs as the result of illness or injury. In the early 1990s, as a direct result of federal attempts to make drastic changes in the way Americans paid for their medical care, large companies began to develop “plans” to manage costs and direct patients’ access to providers. Our patients’ insurance premiums still increased, however. Narrow provider networks appeared and payments to providers were consistently reduced. These trends continue to this day. Insurance companies have in recent years posted record profits while drastic reductions in payments to physicians have forced doctors to close or sell their practices. As a consequence, patients’ access to care has diminished. A small number of companies now insure a large percentage of the patient population, and doctors are unable to participate in realistic negotiations when presented with one-sided contracts. As a result, insurance companies now direct almost every aspect of patient care. Narrow networks have created the problem of forcing patients to seek care from doctors outside their plan.
Years ago, if an illness or injury required urgent treatment, the cost of the care was covered by the patient’s insurance, in whole or in part, with the patient bearing the responsibility for the remainder of the charges. Providers and patients would negotiate these payments just as any transaction is negotiated in a free marketplace. In recent years, the gap between the cost of medical care and payments by insurance companies has grown wider. Because of the enormous power that insurance companies have over the marketplace, doctors have no real choice but to sign their contracts if they want to receive any payment at all and they do the best they can to keep their practices running, oftentimes without success. Today, when a patient receives care from a doctor outside their narrow network, charges for required care are submitted, just as charges are submitted for any professional service in a free marketplace. While I obviously cannot speak to every case, these charges are, in the overwhelming majority of instances, neither surprising nor abusive if one understands the costs associated with providing medical care. If these charges differ from the payments that are typically offered by narrow networks, it is not because physicians make up their charges in some random way on the spot. Rather, it is because for decades, insurance companies have ratcheted payments to ridiculously low levels that do not cover the costs of providing care. If there is any advantage at all for a physician to participate in a managed care plan, narrow or otherwise, it is that the doctor might have access to more patients. If a patient receives care from a doctor outside their network, this doctor does not have in-network access to the plan’s covered patients and has no ability to reduce his or her charges based on the promise of more referrals.

I have seen the population of Gwinnett County more than DOUBLE in my practice lifetime, but the number of outpatient, practicing neurologists has remained essentially static. Despite having the largest neurology training program in the world just a 30-minute drive away from my office, I remain, at age 51, the youngest neurologist caring for outpatients in Gwinnett. This problem is not unique to neurology. Most newly-trained doctors simply cannot afford to go into private practice because of price-fixing by the government and insurance companies.
The legislation that created this committee uses the phrase “abusive balance billing practices.” In today’s environment that has been created by multiple narrow insurance networks, I would expect one could find examples among Georgia’s ten million residents of charges for medical care that might be viewed by some as excessive, but in my experience as a doctor AND a patient, this is quite rare. A much larger problem is that patients suffer EVERY DAY in my community and across Georgia because they have little to no access to the doctors they need. This shortage of physicians is the direct result of price-fixing by third party payers, in an environment where doctors are powerless. This affects EVERY GEORGIAN.

The Study Resolution also references “aggressive collection activity.” I cannot provide state-wide statistics about physicians’ or other professionals’ use of collection activities. My practice does outsource the task of calling non-disabled patients who have not paid their bills after a long period of time; unpaid debt from disabled patients is generally written off quickly. My practice has never in its 30-year history utilized liens or garnishment of wages. I am not sure if physicians’ offices have the legal ability to do these things. We also have never sought to affect a patient’s credit history. We write off an enormous amount of unpaid debt every year.

Efforts or intentions by government to cap ANY professional’s charges, based on contracts they have NOT signed or possibly not seen, are outrageous, and possibly unconstitutional, although I am not a constitutional scholar. No government has the right to tell me, as a private citizen and a professional that receives no government funding, that I somehow need to adjust my charges because I am not part of a given narrow network. I cannot be bound to a contract I have never seen. The idea that ALL doctors might be subject to the contractual terms of ALL plans, whether they have signed them or not, begs the question of why we would even need contracts in the first place. A managed care company could just decide what medical services are worth, and that’s the end of it. And in the context of the care that is provided by a doctor who has not signed a company’s contract, the term “balance billing” does not apply. The term “billing” would be more accurate.
The Federal Trade Commission heavily regulates physicians’ abilities to post or advertise charges for their services. Unlike a restaurant that is free to post its prices on the front door, a physician’s charges are, by federal mandate, basically kept secret. As an aside, a group of obstetricians in Georgia were prosecuted by the FTC for meeting to discuss strategies for offering their services in a way that would save money for Georgia’s Medicaid program. Their offense was publically discussing their fee schedules. Because of this somewhat ridiculous shroud of secrecy, doctors don’t make a practice of posting their fees. In an emergency situation, a doctor may not have the ability to predict even their basic charges, much less those charges that might result as an episode of care continues. Attorneys may be able to tell you their hourly fee, but they cannot always tell you how many hours of charges will appear on their invoice. Should the government cap their charges? A mechanic can tell you the exact cost of replacing the timing belt on a 1999 Honda Accord, including parts and labor, because they are all the same. The delivery of urgent or emergent medical care bears no resemblance to this situation because every patient is unique. My mechanic charges $789 to replace the timing belt on my ‘99 Accord, which is over three times what most narrow network plans pay my practice for all the services my staff and I provide for of evaluating and treating a new patient with a complex neurological problem. These services include, with no extra payment, obtaining appropriate referral information from the referring doctor, assimilating all relevant medical records after obtaining the necessary HIPAA signatures, reviewing those records, evaluating the patient in the office, which may take up to an hour of physician face-to-face time, any and all medical supplies that are used, creating the electronic health record note, which many doctors do at home after office hours, finding the correct ICD-10 codes from the 60,000 options we have to sort through, with threats of non-payment if we pick a code that is incorrect in the opinion of the payer, sending our note to the patient’s other doctors, submitting charges to the insurance company (sometimes multiple times), obtaining precertification from insurance companies for many medications, even generic drugs, and obtaining precertification for many tests, which may take over an hour of staff time per patient visit. Insurance companies often demand a “peer to peer” phone conversation with the doctor in order to allow testing to proceed - and based on
my experience, the company's employed physician NEVER takes the time to review my office notes before requesting a review. Also included with no extra payment are providing enormously laborious safeguards to make sure patients go for their tests, obtaining all reports from outside facilities, reviewing these reports and scanning them into the patients chart, and explaining these results to the patient and/or family by phone. Any patient calls regarding new symptoms, medication side effects, or new treatment strategies are handled with no extra payment as well.

Another confusing problem created by insurance companies is the inability to always know in real time if a given doctor is listed as a provider on a given plan. Insurance companies are constantly changing provider rosters for unclear reasons. Two months ago, several of my practice partner’s claims were rejected by a Blue Cross Blue Shield plan because their automated systems said he was no longer in a particular network. When we called Blue Cross Blue Shield, they had no explanation for why this happened and, in fact, thought he was still on the plan. So the insurance company didn’t even understand its own roster of physicians or why my partner’s claims for payment were denied. How can a doctor possibly know in an emergent situation if he or she is on a given patient’s plan?

I do not dispute the legal right of managed care companies to create narrow networks. They should have the right to do this, just as I have the right to set my professional fees. I do not think, however, that narrow networks serve our patients well, and I dispute the right of the FTC to make me essentially powerless in an unfair marketplace with these companies. Insurance companies need to address the issue of out-of-pocket expenses for patients requiring medical care in an “out-of-network” situation. It is simply not practical to think that a patient will never require care from a physician outside the confines of a narrow network. Provisions for coverage outside of narrow networks should be included so that patients are not left with uncovered expenses.

I am going to conclude my comments on a more personal note. I spent 13 years in college, medical school, residency, and neurology fellowship, and I spent
hundreds of thousands of dollars in the process. I was 30 years old before I was ever paid more than minimum wage. Most doctors have a similar story to tell. In 21 years of practice I have cared for approximately 50,000 patients with neurological diseases in my office in Gwinnett County, as well as in the Gwinnett Hospital System, which includes the second-busiest emergency room in the state. I run my practice, which is a typical small business. I am not an attorney, a statistician, or a public health expert. I cannot comment on state-wide insurance statistics. But I have taken my parents, my wife, my siblings, their children, my friends, and myself to the doctor or a hospital many times. I know what it’s like to be a patient or the loved one of a patient. I have found doctors to be kind, caring, devoted and sometimes expensive. But I was always glad they were there. If the Legislature continues to contemplate price-fixing physicians’ fees, I fear that they may leave their practices in significant numbers.

I hope that we can develop sustainable policies to preserve Georgians’ access to the physicians of their choice, and I thank you again for this opportunity to address you today.