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Good morning Mr. Chairman and members of the committee.

My name is Christopher Wixon. I am a Board Certified Vascular Surgeon in Savannah. In addition to practicing medicine for 15 years, I have served the position of Chairman, Department of Cardiovascular services, spent 5 years on the Board of directors of a large health system in Savannah, and I currently serve on the Board of directors of Merit Independent Physician Association. I mention these to highlight my deep commitment to healthcare of individuals in SE Georgia.

That being said, I must admit that I am clearly more comfortable in an operating room, than I am in this venue. However, personal experiences in our Savannah market has generated sufficient concern for me to set aside my busy clinical practice this day. Specifically, these pertain to the lack of oversight and increasing emergence of inadequately narrow medical healthcare networks.

Without doubt, the development of narrow provider networks by health insurance plans is a cost containment strategy which allows insurers to offer competitive premiums in a particular marketplace. These lower cost products attract price sensitive consumers who are either willing to trade network breadth for lower premiums, or are simply unaware of consequences imposed by the limited services provided by the network. But as interest in the use of smaller networks has increased among consumers, so have concerns about their effect on consumer choice, true impact on costs, and real access to care.

Several aspects regarding insurance make it an unusual product which demands greater legislative oversight:

1. Health care insurance is not a tangible asset. Plain and simple, a health Insurance policy is the fair market exchange of a sum of money for the expectation that future health care needs will be provided. Unlike more tangible products, however, the sale of healthcare insurance represents an expectation that care will be available. By the very nature of insurance, there is no ability to test drive the product at the time of purchase. The consumer is simply purchasing TRUST that an insurer will provide the necessary care when, and if, it is needed.

   In the case of inadequate networks, the consumer's expectation may not match the product that is actually being offered, and individuals are often surprised to find themselves without coverage for unanticipated ailments - suddenly outside of the network umbrella. The problem associated with these so-called "gaps in medical coverage" is severely compounded by the lack of out-of-network benefits, leaving policy-holders with the significant financial consequences associated with purchasing needed medical services from non-participating physicians.

   These products are creating an entirely new class of individuals who are under-insured for particular ailments, which undermines an entire medical community and runs counter to the very intent of federal legislation.

   Just recently, I have witnessed the impact of such a plan. An individual was diagnosed with a life threatening blood clot of the inferior vena cava – the largest vein in the body. The narrow network which insured this individual did not possess an in-network physician with the expertise to treat the ailment. It is a very specialized procedure, so no surprise there. However, I was dumbfounded to learn that the patient's plan provided no out of network benefits for her care.

Tears streamed down her face. It was heart-wrenching to see a patient to be forced to choose between the financial burden of an estimated $20,000 out of network cost versus accept treatment from a physician who had never performed such a procedure. Stories like this are playing out throughout our state.

What is even more remarkable in this case is the fact that the individual who had signed up for the limited healthcare plan was a well-informed, and seasoned primary care physician of greater than 20 years. Clearly, the allure of lower healthcare premiums is the strongest driver of healthcare consumerism. Unfortunately, the consumer cannot understand the gaps in coverage any more than they can understand the long-term carcinogenic effect of yellow dye #25 (a product removed from manufacturing secondary to its risk of causing bladder cancer). Consumers need strong legislation to ensure that the policies meet the expectations of the healthcare consumer and to prevent such harmful products from being introduced into our marketplace.

2. As a means of disclosing services that are included in the policy insurers create provider directories. It is a good start at informing the public about which services are covered. However, our experience has been that these directories are poorly up to date and misleading as to actual coverage in a local market. This is wholly unacceptable and is tantamount to the mislabeling of ingredients of a product.

   As an example, one health plan directory for a carrier currently advertises 52 local healthcare providers. This community has a medical staff of 72 physicians, of whom only 5 actually participate in this health plan. Individuals who selected the plan with the belief that they would have access to the majority of healthcare providers, discovered to that virtually every specialty had no local coverage and that care must be sought several counties away. I could further site examples of referrals of health plan members to my practice who only realize, upon our notification, that their insurance benefits do not allow coverage at our practice. The errant web information took months to correct, during which, individuals continued to assume that our specialized practice was an in-network provider. We need greater oversight of the industry to clean up these practices.

3. Inadequate networks force physicians to perform procedures beyond the scope of their regular practice. Pyloric stenosis affects 0.3% of newborns. Optimal outcomes require early recognition, meticulous surgical technique, and fastidious perioperative support. In the hands of a pediatric surgeon, studies demonstrate reduced complications, length of stay and cost. Despite these resources being available in a particular community, individuals who purchase narrow network policies are often denied such care. Instead, a well-intentioned, in-network general surgeon feels pressured into performing an unfamiliar operation on a newborn for fear that failure to provide in-network care would create a very significant financial hardship for the young family. In no way does this foster an effective healthcare community.

4. DAMAGED PHYSCIAN – PATIENT RELATIONSHIPS. When the complexities of medical care DO require uncovered, out-of-network care, the financial hardships imposed upon the patient create substantial barriers to the ongoing physician- patient relationship. The staggering out of network fees and patient balances create a real reluctance to return to the treating physician for follow up appointments.

Because the vast majority of commercial health plans sold in Georgia are self-insured; they do not fall under the purview of the Department of Insurance. Currently, many health plans sell products that offer no out-of-network benefits. We believe some plans do not fully develop their networks as an intentional strategy in order to insure that additional out of network claims create no financial liability to the carrier. Obviously, in those instances, it leaves the member responsible for the entire bill. It is an extremely dangerous game to play, and one that most healthcare consumers do not understand.

The lack of network adequacy oversight is harming Georgia citizens and is a strong impediment to Georgia's public health. I will site three specific cases which exist currently in our marketplace:

There is a carrier in Savannah that is offering a product to citizens in our region which has no local hospital in its network and only includes 66 of the 1,400 physicians in the market, including 14 uncovered specialties. Under no standard of network adequacy should this network be considered complete; in fact, it is nothing more than a health hazard waiting to happen. Yet, due to the distinct lack of oversight of network adequacy, not only is that network being offered, but it represents one of the lowest cost plans offered in the County. Without doubt, it is likely that it will be selected by many Georgia consumers and will generate membership.

In another case, one other health plan essentially made no outreach to providers, but they did contract with a local hospital. Therefore, subscribers were directed to the hospital for care, but none of the hospital based doctors are participating. So when a patient has surgery, the insurance company pays the hospital but has no benefit for the surgeon, the anesthesiologist, or the pathologist. Therefore, each physician was forced to bill the patient for their service.

In a third similar case, one hospital based group with a Savannah health system was never given the opportunity to join the network; yet they are the only option to provide an entire set of services at that health system. This discrepancy ensured that either the physicians would receive no reimbursement for their services or would cause far higher out-of-pocket costs to the member.

It is my belief that these issues are not aberrations limited to the Savannah market. Based on conversations that I have with my colleagues around the state, the lack of adequate networks for health plan products is escalating out of control. The Exchange plans in Georgia (whose network adequacy is not under the purview of the state Department of Insurance) are exacerbating the issue as many health plans have created commercial health plans that mirror their Exchange offering and are selling these small network products to Georgia's citizens who are not eligible for the Exchange. These plans are enticing for prospective membership as they are typically one of the lowest cost options in the market.

As a board member of Merit Independent Physician Association, my organization is a collection of specialists in the Savannah market who specifically came together to facilitate our physician's move toward quality based, fee for value reimbursement. As a group of committed professionals who are willing to review our cost effectiveness and make changes to improve quality and lower costs, we were stunned to find that the carriers have been unwilling to entertain substantive discussions regarding specialist incentives for cost and quality accountability at this point, nor willingness to share data to facilitate our improvements in the key cost driving areas.

In one case, the carrier representative pointedly shared with us that, given their belief that improved coordination and management could only have a small impact on overall health plan costs, they had no interest is altering the relationships that they have in Georgia. Therefore, I can only conclude that selling inadequate networks at artificially lower costs to members is more profitable for Georgia's insurers.

As a practicing physician, it is a challenge for me to leave my practice for a day and travel to Atlanta, but I have chosen to do so today because of the importance of SB158 and what it means to Georgia's citizens and healthcare providers. If I may, I would also like to briefly touch on the other components of the bill.

First, “Rental” networks may not be the issue that they once were since carrier consolidation has reduced the competition that we once had in Georgia. However, we do from time to time have issues with claims administrators in Georgia who buy discounts from networks after physicians have already seen the patient; therefore, we are unaware of that health plan relationship when we see the patient at the time of their service.

Secondly, the Provider Stability section is a very key part of this legislation. Most carrier agreements in my practice contain language thrust upon us by the unfair playing field that allow the insurer to change the terms of my agreement unilaterially without my signature. As such, key terms, product inclusions, and administrative rules can and do change frequently. As an extreme example, recently, a colleague in my community that was told by a health plan, with which they had been contracted for nearly 10 years, that, if the physicians could not produce a copy of their contract, they would be kicked out of the network unless they signed a new agreement that would be substantially harmful to their practice. Obtaining legal recourse against this kind of carrier tactic would be crucial to physicians in Georgia.

It is frightening how much these health plans are becoming a detriment to Georgia's citizens receiving timely access to care. The all-products clause is a very real concern. During the inception of newly offered plans, many of my colleagues and I frequently do not wish to participate in some of these plans. Yet insurance companies use their all-products clause to automatically "deem" providers into their networks without the provider's knowledge. Many of us never knew we were in network until a patient showed up for care.

In closing, it is my perception that we are losing independent health providers at an alarming rate to early retirement, relocations to other States, or sales of practices due to the burdens that health plans place on providers. I am concerned what the medical community will look like if the legislators do not intervene and create legislation that preserves our medical community.

Finding the proper balance between access and cost, is the crux of the matter. Without doubt, the health care insurers make the case that they are on the side of the consumer by offering low cost options. However, when the resulting provider network is discovered to be clinically inadequate, plans have left individuals subject to the uncovered financial burden associated with out-of-network care and has created real patient harm. We must protect ourselves, from ourselves.

The time has come to create clear legislation which monitors provider relationships, defines network adequacy and provides oversight of companies from mis-labeling, and mis-representing products which have the potential to bring harm to both individuals and to medical communities.

Your commitment to SB 158 gives hope to Georgia's providers and lends protection to our citizens.

I appreciate your time today and I'll be glad to answer any questions that you might have.