Florida Society of
FSASC
Ambulatory Surgical Centers

Dear Speaker Renner

The Florida Society of Ambulatory Surgical Centers (FSASC) applauds you and your colleagues for establishing transparency and patient participation in decision making as a priority this session. FSASC believes that patients must be involved in decision making through out the process. There are however, some practical issues in HB 1549 that are of concern and that will add substantially to the administrative cost of care and may in fact create confusion for patients and delay payments from insurance carriers.

There are over 3 million patients that are served at Ambulatory Surgical Centers (ASCs) in Florida every year. All of those patients receive an estimate of their financial responsibility before surgery. If they request it, the ASC supplies any and all other information that the ASC has available.

Unlike hospitals, ASCs do not take walk-in patients. All of the patients come as a referral from a doctor. The following steps are typical:

- The patient visiting the doctor, receives a diagnosis and agrees to the need for a surgical procedure.
- At that point the doctor contacts the ASC to schedule the surgical procedure.
- The doctor also provides a plan of care to the ASC and contacts the insurance company to get approval for the surgery.
- The ASC then contacts the insurance company to verify coverage and gain an estimate of patient responsibility based on their deductible and copy status, which only the insurer knows.
- The ASC then contacts the patient prior to surgery to make sure they are aware of the cost of care and their estimated responsibilities.

It is important to note that insurance companies have the most accurate and current information concerning a patient's actual financial responsibility in part because a patient may receive multiple services between talking with the doctor and the scheduled date of surgery. The out of pocket responsibility for the patient could change as a result and that information would only reside with the insurance carrier.

It is critical that you retain the “upon request “ provision of the statue as it limits the volume of information provided but enhances the quality of information provided to the patient and reduces the financial impact to the facility and helps to keep the cost of health care down. ASCs are concerned that providing what in effect is an insurance bill prior to surgery will be confusing and misleading to the patient as they would not be certain of what they must pay. It is also important to note that early estimates of insurance charges can also miss unknown charges like those imposed by implant costs. These costs can be unknown prior to surgery, as the surgeon decides what size/material grab, or length or type of screw, anchor or other devices when they visualize the defect during the surgical procedure. Implants costs can often exceed the cost of surgery. Also, as previously mentioned, the ASC might not have the most up to date information. The FSASC members estimate that each ASC would need to add one to two new positions at an enormous cost. Again, the best place to get this information is from the insurance company. Nearly all carriers offer their members online access to detailed information about their specific procedure and options for care from other providers. For cash pay or out of network patients the bill language is more relevant and we believe that all of these patients should receive a more detailed statement of financial responsibility.

We also believe that everyone should receive a cash price estimate but again it may not reflect the actual care if the surgeon discovers additional health issues during surgery. This information is currently disclosed to patients.

We request that you consider reinstating the “upon request” language to the statute as it will substantially reduce the impact on the cost of health care and reduce confusion to patients.

Additionally the bill requires that facilities notify insurance companies much like the notice provided to the patient. As mentioned the first contact with the insurance company is from the doctor. The approval for care also happens at that time. The ASC is usually making contact with the carrier to verify this activity and confirm the patient’s financial responsibility. Also, many ASCs have contracts with carriers that govern notice and approval. It is recommended that the bill language for notice to the carrier focus on out of network care and that it be moved to later in the statute so that it isn’t tied to the AHCA imposed fine provisions. Insurance companies routinely hold back and delay and ultimately reduce payments for services rendered. Adding a provision that they can compel the state to fine a facility seems unnecessary and will only add to the cost of care.

FSASC believes that the current fine language in the state related to fines is sufficient as a deterrent for ASCs as it represents a substantial financial impact on a facility. This may not be true for hospitals as their volume and rates are

substantially higher than paid to an ASC. With the exception of some orthopedic procedures most ASCs procedures are less than $1,000. Moreover, there could be a scenario where a staff simply made a mistake for a day that resulted in incorrect notices to patients and insurance companies. That kind of mistake tied to the $10,000 per notice fine could force and ASC to close. Given the small business nature of ASCs, they are highly unlikely to have sufficient administrative staff and budget to absorb such an increase in overhead expenses, compared to a hospital with much more vast resources, and reimbursement that is often 50% or more higher than an ASC. We ask that you consider leaving the fine provision as it is in current statutes.

Finally, much of the bill is designed to mirror the federal transparency requirements imposed on hospitals. ASCs have not been subjected to those requirements. We ask that you consider removing ASCs from these new requirements or give them more time to comply. Hospitals have been given at least 2 years to comply with the federal requirements. If HB 1549 passes ASCs will have less than six months to comply.

Respectfully

Peter Lohrengel
Executive Director