Testimony Before the
Senate Committee on Health Care regarding Support for SB 523
Presented by Debra Bartel
on behalf of the Oregon Medical Association
April 6, 2015

Chair Monnes-Anderson, Vice-chair Kruse, and members of the committee, thank you for allowing me to testify today. My name is Debra Bartel. I am a member of the OMA Legislative Committee at the Oregon Medical Association. I am also the Clinic Administrator at Portland Diabetes & Endocrinology Center, PC in Portland, a board-certified Fellow in the American College of Medical Practice Executives, current President-Elect for Oregon Medical Group Management Association and a member of the Executive Committee for the Oregon Health Leadership Council. For the past several years it has been my pleasure to assist in many of the successfully completed Administrative Simplification initiatives in Oregon as well as some still in progress.

I am pleased to testify in support of SB 523, a bill that notifies providers about an insurance status that has the potential to affect both the provider and patient's ability to establish or continue care. For patients who obtain a health insurance plan from the exchange (also known as a Qualified Health Plan or QHP) *and* who are eligible for some level of premium subsidy, the Affordable Care Act established a protective 90-day "grace period" to prevent insurers from quickly canceling policies for individuals unable to pay premiums.

For health care providers, the grace period presents a problem as it makes the provider the risk-bearing entity. Insurers are generally responsible for collecting premiums, providing coverage for services for which the insured has paid and bearing the risk if an insured fails to pay their premium. Provider offices are responsible for checking a patient's eligibility with the insurer and using that information to determine the patient's best course of treatment. Unfortunately, federal rules on the grace period did not set requirements on how the provider is notified by the insurer of the patient's grace period status and only require the insurer to cover services rendered in the first 30 days of the period. This means that if the patient does not catch up on their premiums by the end of the 90-day period, the insurer can deny claims for services rendered in the last 60 days of the grace period, forcing the provider to bear the risk of non-payment from the patient for services rendered that were expected to be covered.

SB 523, with either the -2 or -3 amendments, would limit this risk to providers by providing timely notification to the provider, either when the patient's insurance status is verified or when a claim for reimbursement is submitted. If the insurer does not notify the provider of the insured grace period status at either of these junctures, the insurer will be responsible for payment of any claims submitted until the notification has occurred (up to 90 days). Additionally, to ensure that a patient doesn't forgo needed medical services in the grace period, the insurer would be required

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to pay for any ongoing health care services for the duration of the 90-day grace period if the treatment was started prior to the grace period taking effect.

As a clinic administrator and patient advocate, I am intimately familiar with the daily business practices of our clinic and the impact insurance coverage has on our patients. We verify each patient's health insurance status shortly before each visit. Ideally, this is done automatically via a HIPAA compliant electronic transaction with a return electronic response from the insurance payer. This allows us to quickly identify issues and spend less staff time resolving the situation before the patient actually arrives for their visit. If these transactions are not available, we attempt to verify the information via secure Provider Portals provided by most insurance payers or, as a last resort, via a phone call to them. Currently, none of these systems let us know when the patient has entered the 90-day "grace period" for non-payment of insurance premium.

Non-payment of insurance premiums is not a new problem in our industry. Previously, if we billed an insurance claim for services and our patient's individual or group premium hadn't been paid, the payer would send us notification *without payment* letting us know the payment was 'pending receipt of premium. This way we knew our claim would be paid as soon as the insurance payer was paid, allowing us to contact our patient and make sure they were aware of the situation. Insurance plans purchased via an ACA Health Insurance Exchange actually fall under a different set of rules. The ACA requires insurance payers to promptly pay all claims, including the first 30 days of claims for patients falling within this 90-day "grace period". On the surface, this seems to alleviate the burden of delayed payments for providers. However, for patients who are in the grace period, not delaying payment or notifying the provider of the insured's coverage status further delays our efforts to educate patients about their financial responsibility should premiums not be kept up-to-date. Delayed notification results in charges for a rendered service that the patient was not expecting to pay and removes the ability of the clinic to offer the patient financial alternatives, such as a payment plan, *ahead* of the treatment or service.

As I noted above, strengthening the notification requirement creates an opportunity for patient education and reduction in gaps in patient coverage. Providers can counsel patients about the value of health insurance and explore other alternate programs that may be available to the patient, if their circumstances have changed. This not only ensures continuity of care, it takes the burden of potential medical debt off the shoulders of the patient and the provider. However, this can only be accomplished with provider notification.

I would like to thank you once again for the opportunity to address the committee regarding this very important topic and I'm happy to answer any questions.

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