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OREGON MEDICAL ASSOCIATION

MEMORANDUM

To: Rep. Greenlick, Chair, House Committee on Health Care
Rep. Hayden, Vice-Chair, House Committee on Health Care
Rep. Nosse, Vice-Chair, House Committee on Health Care
Members of the House Committee on Health Care

From: Courtni Dresser, OMA Government Relations

Date: May 13, 2015

Re: Support for SB 523-A

SB 523-A simplifies the administrative burden of the federally extended grace period by providing timely notification to the provider of a patient's grace period status during the 90 day period.

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. In Oregon, of the 112,024 individuals enrolled in a marketplace plan in 2015, approximately 77% (86, 258 Oregonians) are receiving an Advanced Premium Tax Credit (APTC).

For health care providers, the grace period has presented 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.

Under SB 523-A QHP's would provide a patient's grace period status when the provider verifies the patient's eligibility and coverage of benefits. If the insurer does not notify the provider of the insured grace period status when a provider requests the information, the insurer will be responsible for payment of the claim.

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Our members are acutely aware of the impact insurance coverage has on their patients. Clinic staff 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 them to quickly identify issues and spend less staff time resolving the situation before the patient actually arrives for their visit. If these electronic transactions are not available, they 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.

Non-payment of insurance premiums is not a new problem in this industry. Previously, if a provider billed an insurance claim for services and our patient's individual or group premium hadn't been paid, the payer would send a notification *without payment* to let them know the payment was 'pending receipt of premium'. This lets our provider's staff know the claim would be paid as soon as the insurer was paid, allowing the provider to contact the patient and make sure they were aware of the situation.

Insurance plans purchased via an ACA Health Insurance Exchange are also subject to separate 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.

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.

Thank you for your support of SB 523-A.

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