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Testimony before the Senate Health Care Committee
April 27, 2017
HB 2339A-eng Balance Billing and Surprise Gaps in Insurance Coverage

Chair Monnes Anderson, Vice Chair Kruse, and members of the committee, my name is Hans Notenboom MD, and I'm the President of the Oregon Chapter of the American College of Emergency Physicians. OR-ACEP opposes HB 2339 A in its current form. Providers sincerely want to remove the burden of balance billing on patients but this bill isn't the right solution. If we want to protect consumers and retain access to care for patients, Oregon needs a fair and transparent reimbursement system based on an independent, non-profit and transparent database such as Fair Health.

What's the problem?
Emergency physicians are seeing patients who have delayed care because of concern about high out-of-pocket costs, whether those be deductibles, co-insurance or co-pays. Patients are facing higher premiums for health insurance but getting less coverage. In effect, insurance companies are shifting costs of medical care onto patient and medical providers. Banning the practice of balance billing without a fair and transparent method of reimbursement creates huge benefits for insurance companies at the expense of health care providers, patients and the medical safety net. It allows health plans to arbitrarily set unfair rates for provider services.

Federal EMTALA laws were passed at the urging of emergency physicians who saw patients turned away for acute care services due to inability to pay. We are proud to serve in the safety net system for patients. This represents emergency physicians' social obligation to our communities. Insurance companies take advantage of this obligation by reimbursing at arbitrary below-market rates without a negotiated contract.

HB 2339 A-eng. sets up two tiers for provider reimbursement. For non-emergency services, it's 175 percent of Medicare. For emergency services, reimbursement rates are tied to a complicated "Greatest of Three rule, or GOT." Reimbursement would be determined by one of three ways; the greatest of:

The median amount, less co-pays and deductibles negotiated for in-network providers; the median negotiated for out-of-network provider or; the amount paid by Medicare for the same or similar service in a geographic area.

Here's our concerns:
The GOT rules is completely unenforceable. The Emergency Department Practice Management Association says medicine reimbursement has gone down after this minimum standard was

implemented at the federal level. Not only that, the rule is currently subject to a legal challenge by ACEP.

Insurers determine their reimbursement levels and formulas in private. There's no way for the emergency physician to check if they are getting paid the same as out-of-network providers. This standard is extremely vague.

Consider that emergency physicians in Oregon, pursuant to the EMTALA mandate, do most of the indigent medical care and two-thirds of Medicaid acute care in emergency departments. And as such, they have little to no operating margins and cannot significantly discount their commercial rates. This reimbursement scheme would destabilize the emergency department safety net.

Forcing OON providers to accept below market rates, may mean that may specialists — surgeons, orthopedists, neurosurgeons and cardiologists, to name a few, will stop taking emergency call. This creates a huge access issue, especially in rural areas.

Insurance carriers are pushing for a "simple" solution such as tying the rate of reimbursement for out-of-network providers to a percentage of Medicare. In effect, this will greatly discount payments to providers. The 175 percent rate of reimbursement provision could cut reimbursement to providers by over 50 percent. This would eliminate incentives for insurers to contract with providers and likely result in more out-of-network providers and less access to care for patients.

In addition, there should not be separate standards for emergency vs. non-emergency, as doing so will have a negative impact in rural ares where there's already limited choice.

Fair Reimbursement Principles

Patients should be taken out of the middle when it comes to the confusing bills — from the insurance company, doctors, hospitals and ambulance — that arrive after an emergency. Insurance companies must be transparent about how they calculate payments and provide fair coverage for emergency patients. Payments must be based on a reasonable portion or percentile of charges, rather than on arbitrary rates that don't cover costs of care. State law should include acceptable or interim minimum benefit standard for out-of-network provider services. This can be determined by using an appropriate percentile of the Fair Health Data Base (www.fairhealth.org) or similar independent and transparent data sources that may arise.

OR-ACEP urges the committee to adopt amendments to do the following:

- First and foremost, the patient is held financially harmless for unexpected Out-Of-Network (OON) care.
- Any patient deductibles and cost-sharing for unexpected OON care are be applied to in-network cost sharing.
- Provider reimbursement must be benchmarked to a non-profit, non-conflicted independent database of billed charges within a geographic area.
- Greater transparency should be required of the insurer in regard to coverage.

Thank you for the opportunity to testify. I'd be pleased to answer any questions.