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Testimony before the House Health Care Committee
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HB 2339 Balance Billing and Surprise Gaps in Insurance Coverage

Chair Greenlick and members of the committee, my name is John Moorhead, MD, and I'm a past president and current board member, representing OR-ACEP, the Oregon Chapter of the American College of Emergency Physicians. OR-ACEP is a medical society that has represented physicians specializing in emergency medicine since 1971 and its members share a commitment to improve emergency health care for all Oregonians.

Balance billing occurs when the health plan reimbursement doesn't fully cover the out-of-network provider charges. Out-of-network providers then bill patients for the unpaid balances. An intense debate over how to address the burden on patients is playing out in Oregon, Washington and in other states across the nation. OR-ACEP strongly advocates for a fair and transparent system of reimbursement for out-of-network providers that will protect patients from unexpected gaps in insurance coverage.

HB 2339, as written and with the dash-1 amendments, while well-intentioned, will not accomplish that objective and may result in unintended consequences, jeopardizing patient access to care. Oregon needs a solution that will bring transparency to health care costs and provide fair coverage to patients.

Hans Notenboom, MD – President
Michelle Shaw, MD – President Elect/Treasurer

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.

Balance billing affects a range of providers including emergency physicians, anesthesiologists, radiologists, pathologists, surgical assistants and other providers often brought in to participate in a patient's care and to meet our federal obligation to 'stabilize' patients. In the emergency departement arbitrary reimbursement may mean difficulty in retaining on-call specialists when payments are reduced.

Patients and providers, consumer groups and insurers all agree the problem needs to be fixed "upstream" and the target should be to address outliers to the system, not to overturn the existing contracting system. The key challenge is agreement on the method to determine fair reimbursement.

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.

The "simple" solution will lead to complex problems

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 in the dash-1 amendments to the DCBS bill, 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.

OMA surveys of providers show more and more physicians are excluding Medicare patients from elective services due to low rate of reimbursement and failure to cover costs associated with providing care. This is why Oregon needs reimbursement for emergency services (which are mandated by federal EMTALA laws), based on actual, usual and customary charges. This would result in patients not being caught in the middle and will remove any 'outlier' charges, which was the original intent of these negotiations.

Consulting specialists need to be adequately reimbursed to remain on-call for ED patients.
This reimbursement is only related to provider services, not hospital charges, which make up the majority of charges a patient incurs when receiving care in an ED. To put in context, most emergency physician charges are in the $300 range, which is why in many states charges above $500 are excluded from this kind of a system to manage the 'routine' charges. Both providers and insurers do not want to negotiate charges for a few hundred dollars. So, while a mediation system is a necessary provision, it should be very rarely utilized.

Bringing clarity to health care costs and health insurance information
Fair Health, a widely recognized independent and verified database, mirrors the healthcare market with an up-to-date rolling average of market-based charges. This or a similar independent data organization should be used to to determine a minimum benefit standards for medical services. (By referencing the 80th percentile, any outlier bills will have been removed from the data set.) In contrast, Medicare fees are adjusted to meet national budget and policy objectives — they were never meant to be a benchmark tied to private payer reimbursement.

Next steps
OR-ACEP respectfully asks the chair for the opportunity to hold hearings on other balance billing legislation that will be introduced shortly. If a workgroup is convened, we'd also like to ask that participants include an equal number of consumers, providers and insurers. Thank you for the opportunity to provide testimony. I'd be happy to answer any questions.