**Senate Health Care Committee**
**May 18, 2018**
**HB 2339A-eng Balance Billing and Surprise Gaps in Insurance Coverage**

Chair Monnes Anderson, Vice Chair Kruse, and members of the committee, the Oregon Medical Association, OR-ACEP, Oregon Pathologists Association, Osteopathic Physicians and Surgeons of Oregon, Oregon Association of Orthopedic Surgeons, and Oregon Academy of Ophthalmology opposes HB 2339 A in its current form.

Providers understand the unfair burden placed on their patients when they receive an unexpected bill for the balance of services rendered but not covered by their insurer. We want to remove this burden from our patients and instead, move the mediation of payment to the parties to whom it applies: the provider and the insurer. As written, HB 2339 A is not the right solution: it does not protect those consuming and accessing the health care system nor increase equity in reimbursement.

The bill as written doesn't achieve those objectives and we urge the committee to consider an alternative proposal.

The provider proposed amendment concepts would accomplish the following objectives;

1) First and foremost, the patient is held financially harmless for unexpected Out-Of-Network (OON) care.
2) It's simplified. If the provider charges for OON services are less than $1,200, the provider will be reimbursed by the insurance company for the billed amount.
3) If the charges are above $1,200, the provider would bill the patient's insurance company based on a set of criteria to be negotiated.

• DCBS may establish a dispute resolution process by rule.

This approach, while not ideal, would address some of the concerns in the bill as written. To re-cap: 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 "Greater 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 with HB 2339A as written:**

**The Greater of Three rules for emergency services are 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.

**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.

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

**Forcing OON providers to accept below market rates may mean that many 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.

**Setting Medicare, at any percentage, in Oregon statute would be precedent setting and could lead to unfair negotiation between health insurers and physicians.** An unforeseen and unintended consequence of this act could lead to health insurers walking away from the negotiation table and leaving more patients with providers out of network. Insurance carriers are pushing for a solution 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 summary, we urge the committee to adopt the compromise amendments or to convene a balanced workgroup to develop a fair and transparent reimbursement system that will take patients out of the middle while still protecting their access to care.