February 13, 2016

Chair Greenlick and Members of the Committee:

Thank you the opportunity to add my group's voice to this conversation. My name is Dan Bissell and I represent Northwest Acute Care Specialists as their President and CEO. I am also a full-time, practicing emergency physician. We are the largest independent emergency physician group in Oregon with over 150 providers caring for a quarter of a million patients annually.

We are acutely aware of the burden of costs in our healthcare system. We absolutely agree that patients should be protected from exorbitant out-of-network fees, just like they should be protected from high deductibles and copays for emergency care.

Our group is contracted with almost every insurer who has any significant footprint in our geographic region, and all of our most recent negotiations have resulted in multi-year contracts. In 2016 less than 3% of our 260,000 patient visits were out-of-network. In most of those cases, the patient was from some other part of the country and the insurer had no local presence. Even in these rare instances, we were usually able to resolve things effectively and to protect the patient from unexpectedly high charges.

We enjoy great relationships with most of our insurance partners. However, we do encounter payers who behave poorly and act in bad faith. When this occurs, emails, telephone calls, and even legal interventions often fail to generate a response. Our only leverage against bad behavior by an insurance company is to cancel a contract. In the past year alone, we have had to threaten to cancel contracts with three large commercial payers. In some cases they downcoded our charts – basically the insurance companies said patients weren't as sick as they really were – and then ignored the appeals process spelled out in the contract. In other instances insurers withheld payments altogether in direct breach of our contract.

In all of these cases we reached out for months to the payers to resolve the issue without any meaningful response. After exhausting all other avenues, we gave notice to terminate the contract. In every case, within days of giving notice we suddenly had the insurance companies calling us back. Ultimately, we were able to resolve all of our issues with these payers and remain under contract with all of them to this day. In any market the ability to enter and exit contracts ensures parity and sustains healthy business relationships. If insurance companies lost the motivation to contract, for example if out-of-network fees were set too low, then they wouldn't care if we canceled or not and their unfair behavior would have gone unchecked.

We strongly support the initiatives to develop a meaningful solution to out-of-network charges and we believe this can be done fairly to the benefit of all three parties involved: the patient, the provider, and the insurer. However, the proposed legislation fails to meet

this goal. The proposed out-of-network reimbursement rate of 175% of Medicare is well below market and, while it might be good for insurance companies, it would have devastating consequences for patients. Rather than contracting at fair rates, insurance companies could cost-effectively force providers out-of-network to accept below market rates. Many specialists – surgeons, orthopedists, neurosurgeons, and cardiologists to name a few – would then stop taking emergency call. Why wouldn't they? Most of these specialists do not depend on emergency patients for their livelihood. Their bread and butter comes from outpatient referrals and elective cases. Already many hospitals in the entire state, rural and metropolitan alike, struggle to offer emergency coverage for specialties such as ENT surgery, hand surgery, and orthopedic surgery. If passed with the proposed fee structure, this legislation could lead to an exodus of specialists from emergency care. Patients will be put in jeopardy as every hospital and emergency department in the state - especially those in rural and critical access areas - struggle to provide emergency care.

The emergency physicians, meanwhile, will be hardest hit of all providers since we are the only specialty completely dependent on emergency patients for our practice. We are required by federal law to see every patient who comes to the emergency department regardless of ability to pay – a fact we take great pride in. The result, however, is that two-thirds of our patients are either underinsured, including many Medicare and Medicaid patients, or have no insurance at all. We rely on reimbursements from privately insured patients to balance out the underinsured and free care we provide. The proposed fee structure will destroy this market balance, creating a paradigm where emergency physicians remain mandated to see every patient regardless of payment, and when we are paid we would have to accept a single artificially low rate that is set unilaterally by an insurance company or through legislation. This would result in a 50% drop in our income. No provider, including your own family doctor, could sustain their practice under these conditions.

Ironically, emergency physicians are not charging the multi-thousand dollar out-of-network fees that are making headlines and prompting these hearings. Yet we could be unavoidably penalized by this legislation while the same specialties that do charge many-thousand dollar balance bills could simply quit providing emergency care altogether with no financial consequences.

There is a national shortage of emergency physicians, and the nature of our practice makes it easy for us to work anywhere. We don't rely on referrals and repeat customers. If emergency providers aren't being paid fairly in Oregon, there really aren't any barriers preventing physicians from moving to another part of the country. Our fear is that this legislation could lead to an inevitable exodus of emergency providers from our state, to specialists pulling out of emergency call panels, and to our state's emergency safety net simply unravelling. This may sound like an alarmist statement but this has been a proven reality in states where a balance billing ban with Medicare based out-of-network fees has gone into effect.

The insurance industry would likely counter that the converse is true – an out-of-network fee that is set above market value could stop providers from contracting with payers and destabilize the market in the opposite direction. Yet our own contract portfolio demonstrates this is not, in fact, true. Our experience has shown that healthy, long-term relationships with contracted payers leads to important business advantages: predictability of collections, shorter time in accounts receivable, and, most importantly, a better relationship with our patients and our own hospitals.

Another concern with the proposed legislation is the plan to tie out-of-network fees to a Medicare rates. Medicare was never meant to be used as a reimbursement model for people with private insurance. It exists as a backstop to protect elderly and disabled patients who cannot otherwise afford care. The Medicare fee schedule has been problematic for years and almost impossible to legislate. Taking an inappropriate model and multiplying it by 1.75 or 2 or 2.5 does not turn it into a good model. To be effective, any out-of-network fee schedule must be tied to real market prices in order to reflect the actual cost structure in our region. There are several good examples of states that have implemented fair and effective out-of-network fees based on available third party databases. These regionally based fee models have met with satisfaction and acclaim from both providers and payers alike.

In conclusion, we support efforts to resolve out-of-network fees associated with emergency care. However, we must do so in a way that preserves and protects our emergency care system. We believe any out-of-network fee structure should be tied to a fair market value that reflects real regional service fees and can periodically adjust – up or down – with changes to our evolving healthcare market. Set appropriately and balanced by an impartial and cost effective dispute resolution system, a fair market approach preserves the incentive for both provider and insurers to pursue mutually beneficial contracts to better serve their patients.

Thank you for the opportunity to join the conversation on this important issue. We look forward to collaborating on an effective solution that protects both our patients and our essential emergency safety net.

Respectfully,

Daniel Bissell, MD
President & CEO
Northwest Acute Care Specialists, PC