US Acute Care Solutions

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Ohio House Bill 388
Testimony of Dr. L. Anthony Cirillo, MD, FACEP
November 20, 2019

Chairman Oelslager, Vice Chairman Scherer, Ranking Member Cera and members of the House Finance Committee, thank you for providing me the opportunity to testify today on House Bill 388.

My name is Dr. Tony Cirillo and I am here today on behalf of US Acute Care Solutions, a company founded and still headquartered here in Ohio. Since its start in 1992 in the Chairman's home district of Canton, US Acute Care Solutions has become the nation's leading majority physician-owned provider of integrated acute care, with a focus on providing emergency medicine services. Here in Ohio, we provide care in 23 emergency departments, staffing hospitals in the Cleveland, Akron, Columbus, Dayton and Cincinnati areas. Our company was started by three doctors who trained in emergency medicine at Akron General Hospital and who began their own small business by staffing a single emergency department at Massillon Hospital. Today, the small business started by those three doctors now employs more than 800 Ohioans. That three doctor company has successfully grown beyond its Ohio roots and now employs more than 3,000 physicians, nurse practitioners, and physician assistants who provide emergency, hospitalist and observation medicine services in 21 states, at over 220 hospitals, where we care for approximately six million people annually.

On behalf of all our providers, I want to express our support for Representative Holmes and his laudable goal to protect patients from surprise medical bills. Based upon the data reported by the Kaiser Family Foundation in October of this year, only 5% of the total number of patients cared for in Emergency Departments here in Ohio may experience an out of network surprise medical bill. The reality is that 75% of the patients seen in the emergency department do not have commercial insurance and are either completely uninsured (~15%) or receive coverage through government funded programs of Medicaid (~35%) and Medicare (~25%). And of the remaining 25% of patients who have commercial insurance, the large majority, 82% are seen by in-network providers. For our company, the economic

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realities of caring for a majority of patients here in Ohio, is that on average we only collect $136 for every patient we care for in an emergency department, regardless of how sick they are. That $136 is actually lower than Medicare payments, and does not even cover the cost of providing services. Any legislation that reduces payments by commercial insurers will only make it more challenging for us to continue to staff the emergency departments and to recruit and retain physicians here in Ohio.

We do understand that receiving a bill for out-of-network care, and being responsible for a higher deductible, if you were cared for by an out-of-network provider or at an out-of-network facility, can be financially difficult for our patients. In HB 388, we are specifically supportive of the concepts of "bundling" which will reduce the number of arbitrations and also for creating parity for in-network and out-of-network deductibles. Although we share Rep. Holmes' goal of protecting patients from surprise medical bills, we are concerned that HB388 as proposed, will not achieve the desired result of protecting patients from surprise medical bills. Although the language of HB 388 references a "greatest of three" standard, the reality is that the "median in-network rate" will become the single government-mandated benchmark rate of payment. By legislating a government-mandated median benchmark rate, the State of Ohio will be incentivizing behavior by both insurance plans and providers that could lead to a decrease in the in-network contracting rate and increase the number of patients seen by an out-of-network provider. By setting the out-of-network payment at a median rate determined by the insurance company, a number which is known only to the insurance company with no transparency to providers, insurance plans would be financially incentivized to terminate the contracts of all providers with in-network contracts above the median rate, which would drive down what the plan determines as the median rate. Conversely, any provider who had negotiated a contract below the median rate would be incentivized to terminate their contract and effectively increase their payments by going out of network. These incentives could theoretically lead to a situation where almost no providers were in network, solely based upon this legislative language. In addition, setting a government-mandated rate for care ignores the important factors that allow providers to differentiate themselves based upon quality performance and investment in quality programs, as well as other factors that are a normal part of the contracting process. Lastly, the arbitration process as defined in HB 388 is flawed in two aspects.

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First, the language of HB 388 provides for arbitration where the arbiter may only rule on the "accuracy" of the payment made, not on the "adequacy" or fairness of the payment. The arbitrator should, as has been established in other states, be allowed to consider a number of important factors in determining what a "fair" payment is including the complexity of care provided, the history of previous in-network contracting, and other data provided by both parties. The second flaw in the current legislative language is in the mandate for a 70/30 percentage split in payment of the cost of arbitration. This 70/30 split does not reflect a true "baseball style" arbitration where both parties are encouraged to make their most reasonable "best and final offer" for consideration by the arbitrator. The 70/30 split in effect means that whichever side "wins" in arbitration, still loses. For example, a provider who was successful in winning an arbitration would be awarded the "fair" payment, but still be responsible for paying 30% of the cost of arbitration effectively making the payment now "less than fair" as determined by the independent arbitrator.

In addition to still caring for patients in the Emergency Department, which I have done for 25 years, I serve as the Director of Government Affairs for US Acute Care Solutions. In my role, I have been involved in the development and drafting of legislation to ban balance billing in many states and at the federal level over the past five years. As we all know, every state is unique in terms of it's political, socioeconomic, and demographic makeup. However, despite these inherent differences, we have seen good legislation, that represents a fair compromise amongst all stakeholders, pass in a number of states. In 2018 alone, legislation has been enacted into law in the blue, red, and purple states of Washington State, Nevada, Colorado, and Texas. The legislation signed into law in each of those states most importantly protects patients from any balance or surprise bills for emergency medical care. In all those states, the laws are based upon the identical framework of an initial payment for services provided, with the availability of a simple, online, expedited backstop arbitration process based upon fair and reasonable criteria to determine the appropriateness of a payment made to an out-of-network provider.

New York State implemented this IDR process with "baseball style arbitration" in 2013 and has the longest history and most comprehensive data set to evaluate. An analysis of the data from New York in

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2018, as reported by Zack Cooper, Associate Professor of Public Health & Economics at Yale University, demonstrated a 34% reduction in out-of-network billing and a 9% reduction in the level of in-network emergency department physician payments in the state. Cooper states in his report, *"Ultimately this policy disadvantages providers that bill for unreasonably high charges and punishes insurers that offer unreasonably low initial payments. The law also encourages physicians and payers to negotiate independently and avoid arbitration."* In September of this year the Superintendent of the New York State Department of Financial Services, which oversees the IDR process, issued a comprehensive report on the IDR Process for the Out-of-Network Protection Law. The report documents that use of IDR has been extremely low, used in only 0.02% of visits to emergency departments. The report documents that consumers personally saved over $400,000,000 since its implementation in March of 2015 and is described by the Superintendent as *"a true success in bringing stakeholders together to solve the problem of excessive charges for emergency services and surprise bills".*

Today, on behalf of US Acute Care Solutions, I want to again thank you for the opportunity to testify on House Bill 388. Although HB 388 incorporates some important provisions to protect patients from surprise medical bills, we are concerned that it will have unintended consequences of increasing the out-of-network exposure of Ohioans and creates an unfair, government-mandated benchmark payment to providers who are staffing our emergency departments on a 24/7/365 basis. We look forward to working with the Committee on this important issue to ensure that ALL Ohioans are protected from balance surprise medical bills through this comprehensive and fair legislation.

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