Ohio ACEP
American College of Emergency Physicians
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House Bill 166
Testimony of Dr. Brad Raetzke
May 16, 2019

Chairman Hackett, Vice Chairman Huffman, Ranking Member Thomas and members of the Senate Finance Subcommittee on Health and Medicaid, thank you for the opportunity to express concerns to several provisions added to substitute House Bill 166 in the House of Representatives.

My name is Dr. Brad Raetzke and I am the President of the American College of Emergency Physicians, Ohio Chapter (Ohio ACEP) and a practicing emergency physician in Central Ohio. On behalf of the nearly 1600 emergency medicine physicians Ohio ACEP represents, I hope to shed some light on the detrimental impact provisions directly targeting emergency care could have on vulnerable populations in Ohio.

As I am sure you are well aware, the emergency department is a fast-paced and complicated practice environment. Emergency physicians see and treat conditions that cross the entire spectrum of medicine. We see every patient that walks through our door regardless of presenting symptoms, insurance coverage, medical history, etc.

Emergency physicians and emergency departments practice under a federal mandate EMTALA (the Emergency Medical Treatment and Active Labor Act). This mandate requires that every person who comes to the ED be seen regardless of their coverage status or ability to pay. We also have to treat patients with limited medical history and information. We have our doors open 24 hours a day, 7 days a week, 365 days a year. We are the true safety net of the health care system.

Our association would like to discuss several provisions that were added to HB 166. These issues are very complex, with a variety of factors and possible consequences. As these provisions could have extreme impacts on the healthcare safety net, I implore you to give them thoughtful consideration as you explore changes to the bill in the Senate.

1. ORC 3902.50 and ORC 3902.51– These provisions are intended to address the issue of "surprise bills." Ohio ACEP wholeheartedly agrees that this is an issue that needs a solution. In fact, we have been working on this issue for at least the last three years with other interested parties. This is a national issue. Our national association has instituted weekly calls to discuss ways to address the issue and receive updates on activity in other states.

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Recently, ACEP had an advocacy day in Washington DC, and this issue was front and center for our members. I have with me a few of those materials to demonstrate Ohio ACEP's commitment to solving the very real problem of "surprised bills" and keep patients out of the middle of disputes between providers and insurers. Our national model also addresses the issue of high deductible plans and narrow networks, which the language currently in HB 166 does not.

We believe that high deductible plans are a primary component of the surprise billing problem. With insurance companies having the ability to be out of network for EMTALA related services they are able to place higher deductibles on their patients plans and shift an increased burden of cost, and often entire portion of the bill, to the patient. This is a concerning example of how insurance companies drive to be profitable often leads them to take advantage of our patients and EMTALA related care.

The provisions included in HB 166 states that for emergency care, if a patient is seen by an out-of-network provider, the provider shall be reimbursed the greater of average contracted rate for the same service or the out-of-network rate. This sounds like a fair solution. However, the bill does not define these benchmarks in a manner that provides any clarity. The main problem is that these are both non-transparent and under the control of the insurance plans. The physician has no way of knowing how these rates are determined, nor is it possible for the physician to know if he/she has been reimbursed correctly. The reality is this would cause insurance companies to drive down rates or fail to contract with providers. There are essentially no protections for the provider. There needs to be a more transparent and independent benchmark for these rates.

As I stated, emergency physicians cannot turn anyone away who walks through our door. Federal law mandates that. We can not discuss potential costs or insurance details until patients are screened and stabilize. We are hoping the legislature will consider an alternative out-of-network coverage policy that does not disproportionately disadvantage the physicians caring for the most vulnerable Ohioans.

Even the arbitration provision, which is no doubt well intended to protect the provider, is not clearly written and could be interpreted in several ways. We are working on an alterative proposal for your consideration.

The State of New York was able to adopt a law that has almost eliminated surprise bills. Data has shown that insurance premiums and healthcare cost in the state have grown more slowly than the nation. Ohio ACEP is working with other groups on drafting this model for Ohio as a fair alternative to the language currently in HB 166.

The issue of surprise bills and out-of-network coverage is very complex and nuanced and deserves proper vetting by all parties.

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2. ORC 3727.49 – This provision creates new regulations on free standing emergency departments.

   Free standing emergency departments are full service emergency departments. They are not an urgent care as we have heard some contend. Free standing EDs are open 24/7/365 – urgent cares are not. Free standing EDs must comply with EMTALA – urgent cares do not. Free standing EDs have diagnostic and treatment capabilities that urgent cares do not.

   They see sick patients who have heart attacks, strokes, sepsis and are often the first line in caring for devastating traumas. Freestanding EDs allow patients to seek treatment for many illnesses and injuries close to home.

   They allow ambulances to return to service faster due to shorter travel distances. They are a way to provide definitive care to communities that would not be able to sustain a full service hospital. In a soon to be published study, one of our members demonstrated that FSED's do indeed see real, sick, patients who belong in an ED and do so faster and with higher patient satisfaction. They do not discriminate based on ability to pay.

   Since free standing EDs must be compliant with EMTALA, they cannot do, say, or post anything that might discourage a patient from seeking care. The signage provisions of Section 3727.49 likely would be an EMTALA violation.

   Even when working to create emergency department prescribing guidelines to educate patients as they entered the emergency department, states, including Ohio, were cautioned by CMS that signage or notices that COULD be a deterrent to obtaining necessary care would result in possible EMTALA violations.

   As these provisions have not been fully vetted, they should be removed from the bill. The EMTALA implications must be fully explored before opening up hospitals to risk.

3. ORC 5164.722 and 5167.201– These provisions target the Medicaid population for ED utilization. We have not seen any data to show that Medicaid recipients inappropriately access the emergency department. Nor have we seen data that shows that emergency department reimbursements are a large portion of the Medicaid budget. In fact, CDC data has shown that only about 5% of emergency department visits are classified as non-urgent after the physician has performed their medical screen and stabilization care. The provisions only seek to financially punish emergency physicians and emergency departments for providing the safety net healthcare that most others won't provide.

   The language essentially states that after the EMTALA required medical screening and stabilization care is complete, an invisible clock stops and the emergency physicians should cease care or receive a lower reimbursement rate. This language is not in the best interest of Medicaid patients. Imagine a scenario where a patient comes to the ED after a car accident. They have suffered several lacerations.

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If this provision were to become law, the ED physician could be expected to examine the patient, determine there is not an immediate risk to the patient's health or welfare, and then send them to another location, like an urgent care or their primary care, to have the lacerations stitched and bandage. And frankly we have also heard that some urgent cares will not do stitches. What is the patient supposed to do? How is this in the best interest of the patient?

These provisions are unnecessary and should be removed from the budget. Enacting these would adversely impact those who are most vulnerable, such as the poor and medically underserved and further restrict their access to care.

Thank you for your consideration of this perspective. Ohio ACEP has always been and will continue to be willing to discuss these important topics with members of the General Assembly. I welcome the opportunity to answer any questions you may have.

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