COMMUNITY EMERGENCY MEDICINE PARTNERS

Chairman Oelslager, Vice Chairman Scherer, Ranking Member Cera and members of the House Finance Committee, thank you for taking the time to receive and review my testimony today in opposition to the current version of House Bill 388 regarding the topic of out of network billing.

My name is Gary Katz. I am an Emergency Physician serving rural communities at critical access hospitals in Ohio. Though I have been in practice since 2001, the group I helped found has been in existence since 2018. Previously, I have worked as an Assistant Professor at The Ohio State University, and have helped manage multi-state, multi-specialty practices in various urban and rural environments.

Not long ago, it was demonstrated that rural hospitals and associated emergency departments are a critical need for their local populations. It has been proven that when a rural hospital closes, the local mortality rate increases 5.9%[1]. Yet, this risk of death is not limited to the rural population, for it was further shown that when a rural hospital closes, the nearest urban center mortality also increases by 2%[2]. Clearly, rural health impacts all, no-matter where you choose to live. As physicians in Ohio we have to care for all residents regardless of where they live.

Given that nationally over 113 rural hospitals have closed in the last decade, the need for attention to this matter is reaching a tipping point. For this reason, I decided to focus this next stage of my career on bringing excellent emergency medical care to rural communities and supporting the local hospitals, and the patients they serve with both fairness and justice.

As we set up our new group, which is a small business, we sought collaborative relationships with insurance companies. It was at that time that we experienced an apparent ugly underbelly of the insurance industry. Even as we attempted to be collaborative, the insurance companies would use every ounce of leverage to collect premiums from patients while denying us the opportunity to be in-network. Allow me to share a specific example.

In 2018, we obtained our first rural contract. As stewards of the communities we serve, we sought to be in-network with the same payors as our hospital partners. As a new

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[1] The National Bureau of Economic Research, Working Paper No. 26182, Issued in August 2019

[2] Renee Y. Hsia, Yu-Chu Shen Emergency Department Closures And Openings: Spillover Effects On Patient Outcomes In Bystander Hospitals, Health Affairs, Vol.38 No 9, Sept 2019

group, we are small, so carry minimal influence over the rates we are offered. We researched the market and attempted to achieve rates that allowed us to be competitive with urban centers for recruiting yet remain fair as described by commonly used accepted databases for selecting our payment rates.

In each case, we received offers far less then these accepted rates, and from some commercial payors we received proposals far less than Medicare. We did ultimately negotiate and settled on rates that we felt would be a place to start, so we could be in-network. We believed our improvement in care and other metrics would justify future rate increases, and we believe they indeed do with 4 of 6 MIPS (Merit-based Incentive Payment System) scores being in the 99th percentile.

Once in-network rates were agreed upon, we believed the paperwork, or contracting, shouldn't take long. We were wrong.

For one payor, we waited four (4) months for them to send us the in-network agreement. During this time, we contacted the payor on a regular basis to inquire about the status of our contract. We rarely heard anything back. We even enlisted the aid of our hospital partner's executive suite to call on our behalf; still nothing. We were beginning to believe they were going to renege on the agreement we had.

We eventually received the contract. It was the terms to which all parties had agreed. We signed this term sheet quickly and then were told we would remain out of network for six (6) weeks while they "loaded" their rates into their computers.

During this four to six (4-6) month period, we were out of network against our will. The insurance company collected payments in the form of premiums from their policyholders, yet forced us to decide the manner in which we would have to collect from patients, and in which situations we would simply write off the cost as a measure of good faith to the community.

Such action has harmed us as a business and has threatened our ability to provide care to the critical access communities we serve.

Behaving as bad actors, seems to have become an apparent standard in the insurance industry: (1) Refuse to come to the table, or only arrive with offers that are barely sustainable to cover overhead, especially when dealing with individual providers or small groups, (2) come to an agreement, but delay the process so they pass the cost directly to the patients, (3) muddy the waters to hide insurance's role in the rising costs of healthcare and make it seem the small sum paid to emergency physicians is THE burden driving costs, when it really is not.

It is our desire that an out of network billing solution be found and acted upon. We believe that using appropriate Independent Dispute Resolution with a reasonable threshold, applying an independent database driven guideline, and holding insurance

companies accountable to their attempts to sidestep their responsibility to pay according to their subscriber agreements is critical.

Without such action, Rural Ohio Communities will suffer, and small businesses will suffer right with them.

Thank you for consideration of this important perspective. I hope the committee will not move forward with the current version of HB 388 and instead consider a more fair and reasonable solution to surprise billing.

Sincerely,

Gary R. Katz, MD, MBA, FACEP
President and Chief Medical Officer