Cleveland Clinic

House Bill 99 – Proponent Testimony
Ohio House Insurance Committee
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Chair Lampton, Vice Chair Barhorst, Ranking Member Miranda, and members of the Ohio House Insurance Committee, thank you for allowing Cleveland Clinic to provide proponent testimony for House Bill 99, which would regulate the practice of reducing benefits related to emergency services if a condition is determined, after the fact, not to be an emergency. My name is Bradford Borden, MD, and I am the Chair of the Emergency Services Institute at Cleveland Clinic.

The Emergency Services Institute at Cleveland Clinic cares for over 500,000 adult and pediatric patients annually across our 14 emergency departments, including our Main Campus in Cleveland, 8 regional hospitals in Northeast Ohio, 3 free-standing emergency departments, and 2 pediatric emergency departments. In an effort to deliver world-class care, we have attained the 90th percentile of all emergency departments in the United States in time it takes a patient from arrival to see a provider. We have also been the recipient of the Press Ganey Guardian of Excellence Award, which recognizes emergency departments in the 95th percentile for providing outstanding patient satisfaction, at both our Richard E. Jacobs (Avon) and Twinsburg free-standing emergency departments.

'Patients First' is the mission of Cleveland Clinic, which is why passage of House Bill 99 is so vital. This legislation addresses a current practice in which insurers are retroactively denying coverage to patients who have sought care at an emergency department if the patient's condition is later determined not to have been an emergency. This leaves the patient with an unexpected – or "surprise" – bill. While we are grateful that the state and federal legislatures passed surprise billing legislation in the previous General Assembly, we feel this practice of retroactive ED denials also needs to be addressed in order to make sure we are fully protecting the patient and removing any financial barriers to seeking lifesaving care. This practice is affecting insured patients who go to an emergency department believing they are suffering an emergency, only later to find out their insurance is denying the claim because retroactively someone felt it wasn't an emergency. This leads to the patient being responsible for a large bill despite having appropriate insurance coverage.

There are several reasons why these scenarios occur and not at the fault of the patient. In order to better illustrate the problem with this practice, here is a real-life example of a pediatric patient who went to an in-network emergency department at the direction of his primary care provider (PCP) and subsequently was told by the insurance company that the visit would not be covered because retroactively it was felt to not have been an emergency. The child had been seen by his PCP the day before, after three days of a fever, and was diagnosed with a viral illness. The parents were told by his doctor to go to the emergency department if the fever did not go away or if the child would not take fluids. That night, the child woke up febrile, and he would not take Tylenol. Therefore, the parents were unable to control the fever. They had nowhere else to go in the middle of the night and had discharge instructions from the PCP office to go to the emergency department for this exact scenario. The parents took him to the emergency department with a fever of 104.5 degrees Fahrenheit; the care team was able to improve his fever, ensure he was able to take adequate fluids, and diagnose him with the flu. Ultimately, he was safely discharged home. The family later found out this visit was not covered, and they

were financially responsible for the entire bill despite having insurance that covers emergency visits and despite having gone to an in-network location. It is easy to imagine that this added to the significant stress of needing to seek care for a very sick child in the middle of the night.

This is just one example of many that we see across our health system. The administrative costs involved with reviewing and appealing these claims are unnecessary and burdensome. In today's model, payers often seek to review detailed medical records on many of these cases to determine if the patient should have been seen in the emergency department. This is a new and costly burden for providers with, in some cases, payers demanding a manual review of over 20% of the emergency department visits prior to the provider receiving any payment for the claim (and a subsequent appeal if denied). Further, it is very difficult to track these cases. We often only become aware of some of these through complaints within our ombudsman's department, as the traditional denial mechanisms aren't followed, and instead the patient is forced to navigate a very complex process.

We understand that payers are seeking to control the cost of avoidable emergency department services, but if a patient's presenting clinical condition is appropriate to be seen in the emergency department, the benefit should not be denied. We propose that the payer make the benefit and payment determination solely from the presenting diagnosis, and eliminate the use of diagnosis lists to drive reimbursement.

The emergency department is a unique setting, as patients present with acute, undifferentiated complaints requiring medical expertise and diagnostics to determine the cause of their symptoms. Medicine is not straightforward, as life-threatening diseases can present with a wide variety of symptoms, ranging from mild to severe. I've seen heart attacks that present with arm pain and I've seen individuals with crushing chest pain that is secondary to acid reflux. But, all of these patients deserve an assessment from an individual trained to treat and identify emergencies. And, under no circumstance, should fear of being responsible for a bill force a patient to make a decision regarding what could potentially be a fatal misdiagnosis. There is a reason why morbidity and mortality rates continue to drop for conditions like sepsis, stroke, and heart attack as we improve our diagnostic capabilities and efficiency. Forcing a patient to make a decision of whether their chest pain is a heart attack or heartburn over fear of being responsible for the entire bill is not in the best interest of Ohioans.

House Bill 99 will restrict this practice by strengthening and clarifying the existing prudent layperson standard and also will stress that it applies regardless of the final or presumptive diagnosis. The prudent layperson standard means that if a person with average medical knowledge believes they have an emergency medical condition, the visit to the emergency department should then be considered a medical emergency. Passage of this bill will improve patient care and can potentially save lives by not deterring patients from going to the emergency department out of fear that they may be expected to cover the cost out-of-pocket.

Once again, Cleveland Clinic supports House Bill 99 and urges the committee to be supportive as well. We thank the sponsor, Representative Susan Manchester, for introducing this bill and working with interested parties along the way. Thank you for the opportunity to testify. I can be contacted with any questions you may have.