Ohio ACEP
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Ohio State Medical Association

House Insurance Committee
Dr. Eric Drobny – House Bill 99 Proponent

Chairman Lampton, Vice Chairman Barhorst, Ranking Member Miranda and members of the House Insurance Committee, thank you for the opportunity to provide testimony in support of House Bill 99. My name is Dr. Eric Drobny. I am a member of the Board of Directors of the Ohio Chapter of the American College of Emergency Physicians (Ohio ACEP) as well as the President of the Ohio State Medical Association (OSMA). I practice emergency medicine in Central Ohio and serve as the CFO of Emergency Services, Inc., an independent group of 50 emergency medicine physicians.

On May 10, 2023, this committee heard proponent testimony from Ohio ACEP President Dr. Bryan Graham as well as receiving supporting testimony from the OSMA and other organizations. The goal of HB 99 is to protect Ohioans from unexpected medical bills due to their insurer denying claims for emergency care, after that care has been sought and provided. The bill is also intended to protect our healthcare safety net, the emergency department, by ensuring coverage of emergency services are provided fairly by requiring the insurer to review the medical claims before issuing a denial or reducing the benefit for the claim. The emergency department is the only healthcare setting that is available to Ohioans 24 hours a day, 7 days a week, 365 days a year. It is vitally important that patients do not delay seeking emergency care out of fear that their insurance carrier will ultimately not cover the visit.

This committee has also heard from the insurance industry with their opposition to this legislation. Today I hope to respond to some of those opposing remarks.

HB 99 is a tool to ensure proper coverage of emergency care, without the healthcare system having to go through costly litigation to hold insurers accountable. We are seeing more and more of these unfair practices by insurers being litigated in court. These lawsuits also add costs to the healthcare system. For example:

> The U.S. Department of Labor has filed suit against UnitedHealth Group claiming they have illegally rejected emergency room care and urine drug screen claims for thousands of people.
>
> A health system in Virginia is suing Anthem Blue Cross Blue Shield for at least $93 million in unpaid and reduced claims.

In testimony from the Ohio Association of Health Plans they stated: *HB 99 encourages the use of the Emergency Room (ER) in non-emergency scenarios, which would result in increased wait times in an emergency and increased health care costs for Ohioans.* I wholly disagree with this argument. To insinuate that patients might prefer to receive their care in the emergency department as opposed to other settings like an urgent care or their primary care physician is just not my experience. Our patients come to the ED because they feel like it is their best available option. The OAHP uses the example of poison ivy as a non-emergency condition. But in the middle of the night, a person with a history of severe reactions, or concern for an overlying infection, will probably deem the ED a very appropriate setting to be seen for their poison ivy.

Furthermore, that example of ED utilization is certainly nowhere near as typical as the patients who present for chest pain, shortness of breath, and abdominal pain. It is these patients who are having their claims inappropriately denied that HB 99 is addressing.

This is why HB 99 is designed to require the medical utilization review on the front end of the claim processing. The bill does not prohibit denials or mandate specific coverage levels for any services. But an insurance companies' algorithm of diagnosis codes can't decipher the nuances of abdominal pain, chest pain, shortness of breath, or even poison ivy. It requires an actual review of the medical chart to determine if that visit met the prudent layperson standard. As discussed at the June hearing though questions from the esteemed committee, when a claim is denied as "non-emergent" the burden is on the patient to appeal that claim, and in many circumstances, those appeals go in favor of the patient. That is additional administrative burden on the healthcare system and could be avoided if claims are reviewed by the insurers in the first place. Further, the bill does not require the insurer to use the utilization review for the ALL claims, only before denying or down coding a claim.

We understand members of this body are concerned about the overutilization of emergency departments and want patients to seek care in lower cost settings. However, there are already many tools in place to promote appropriate site of care selection for medical issues, including co-pays. I am sure many of you in this room have substantially higher co pays if you go to the ED then if you go to an urgent care. So, this notion of overutilization is not valid.

Furthermore, once they present to the ED, as an emergency physician, I am required to see them. The emergency department is the only place that is open 24/7/365 and in response to questions at the committee hearing in June, emergency departments are the only setting required to see all patients. An urgent care does not have that same obligation. Your primary care physician does not have that same obligation. Once I give a patient the required medical screening and rule out any life-threatening ailment, I am most likely going to refer them to their primary care physician for follow-up. I am not going to set an appointment to see them again and truly *encourage* them to utilize the ED.

Members of this committee, I ask for your support of this important legislation. I'd be happy to answer any questions you might have.