Oregon debates payment parity
• Bill would mandate equal pay for doctors, nurse practitioners

By Markian Hawryluk / The Bulletin

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As often is the case in health care, something that seems simple can wind up being very complicated.

A bill in the Oregon legislature that would require private insurance companies to pay nurse practitioners the same rates as doctors for the same services has become stuck in the tangled web of health care financing. And lawmakers may not be able to untangle that mess in the short time left in this year’s abbreviated legislative session.

At the heart of the matter is a debate over whether health care services, such as routine check-ups or treatment of an ear infection, should garner the same payment rate from an insurance company regardless of who provides that service.

Or should payment rates differ based on the training and expertise of the person providing the service?

Nurse practitioners are registered nurses who go through additional training to serve as primary care providers, with the ability in Oregon to diagnose and treat conditions, prescribe drugs and operate independently of physicians. Some nurse practitioners go on to specialize in treatment areas such as mental health or women’s health.

States differ in how much autonomy they grant nurse practitioners, but Oregon was one of the first states to license nurse practitioners, and has generally been ahead of other states in expanding their use and scope of practice. In many areas of the state, particularly in rural Eastern Oregon, nurse practitioners represent the only primary health care option available.

Payment rates for nurse practitioners also differ greatly from state to state and among public and private insurance plans. Medicare pays nurse practitioners at 85 percent of the rate paid to physicians for the same services, and many private insurance companies follow that payment structure.

Payment rates became an issue in Oregon in 2009 when several insurance companies opted to cut payment rates to nonphysician mental health providers, including nurse practitioners, from 85 to 65 percent of physician payment rates. In subsequent years, some insurers have cut their payment rates to nurse practitioners in primary care settings as well.

Nurse practitioners cried foul and appealed to lawmakers, who introduced a bill this year that would require private insurance companies to pay nurse practitioners and physicians at the same rate in non-HMO plans.

“This is not a nurse practitioner versus physician issue,” said Susan King, executive director of the Oregon Nurses Association. “This is a fairness issue. It’s a recognition that particularly in primary and mental health care, our capacity is insufficient right now, and it’s only going to get worse.”

The group argues that such reimbursement cuts are forcing nurse practitioners to cut staff or even close their practices because they cannot cover their costs.

“The business costs are largely the same whether it’s provided by (a doctor) or a nurse practitioner,” said Tay Kapanos, director of state policy...
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for the American Association of Nurse Practitioners. “We see this as an access-to-care issue. It’s an issue about fair competition.”

Separate or equal

Nurse practitioners and their supporters have framed the measure as “equal pay for equal work,” but physician groups reject the notion that all things are equal.

“We go through 11 to 13 years of training,” said Dr. Carla McKelvey, president of the Oregon Medical Association. “A nurse practitioner is typically going through five to seven years of training. So it’s almost twice as much. And that education comes at a price.”

Physicians come out of medical school with an average of $141,000 in debt, while nurse practitioners average about $64,000 in debt, she said.

“On top of that, because we are physicians, we have a higher liability risk, and that liability risk is from the assumption that we have a greater expertise,” McKelvey said. “Our liability costs are three times that of a nurse practitioner.”

Physicians are also concerned that the bill only mandates payment rates be the same for both nurse practitioners and doctors. Insurers could just as easily lower physician payments as raise payments to nurse practitioners under the bill. It doesn’t guarantee that insurers would reverse the payment cuts to nurse practitioners.

“We feel very strongly that that was unfair, that they should not have done it and that’s what needs to be fixed,” McKelvey said. “What this bill does is it takes a very complicated problem and tries to simplify it.”

For one, insurance companies don’t have a single physician payment rate even within a single geographic area. Plans contract with providers at various rates and can take advantage of a competitive market to drive down the cost of care. The bill does not specify how plans would determine which physician payment level would be the rate for nurse practitioners.

Additionally, many nurse practitioners work as salaried employees of a clinic and there is no provision to ensure those clinics would pass along the additional payment to the nurse practitioners. In many cases, nurse practitioners working in a physician clinic are able to bill under the physician’s billing number anyway and receive the physician payment rate.

Insurance companies have opposed the bill, suggesting it would drive up costs for consumers and wouldn’t address access issues where they exist.

“We don’t go about arrangements with practitioners in an unthinking way. We look at what the availability is in a particular area,” said Tom Holt, director of government relations for Regence Blue Cross/Blue Shield of Oregon. “If we’re talking about a small community where a nurse practitioner or another midlevel provider is primary care, and there is no one else, they get paid differently than in a place where there are lots of choices.”

Controlling costs

The payment parity issue puts nurse practitioners in a bit of a conundrum. They’ve often been seen as part of the solution to rising health care costs, because they cost the health care system less than physicians. But if legislators mandate payment parity, there is less incentive for states or the federal government to invest in nurse practitioner training programs or other initiatives to boost their supply.

Nurse practitioner groups counter that studies have shown nurse practitioners tend to practice more efficiently than physicians, keeping their patients healthy and out of the hospital or emergency room, where costs really skyrocket.

“There are numerous studies that show that nurse practitioners are cost effective beyond our salaries, that it is the preventive services that we provide, it is the counseling that we provide, that not only help people to get healthy but to stay healthy,” Kapanos said.

As health reform discussion heat up, the role of nurse practitioners in the spectrum of health providers is likely to be a common theme. Increasingly, clinics are organizing around a patient-centered medical home model, where the patient is cared for by a team of providers rather than a single doctor. Under that model, if nurse practitioners and even physician assistants can treat the most complex cases they’re trained to treat, it could take the easier cases off of physicians’ plates. Doctors could then concentrate on the cases that require more extensive medical
training.

“We want to be able to encourage people to go to the right level of care. If they need a high level of care, go to a higher level practitioner. If they can get good quality care with the midlevel practitioner, the nurse practitioner, that’s where they should go,” Holt said. “That stops making sense if they cost just as much.”

With so many unanswered questions about how the bill would work if passed, lawmakers are still unsure how much the payment parity mandate would cost, and insurers can’t say how they would offset the higher payments under the mandate. In all likelihood, they’d pass those additional costs on to consumers.

“To the extent that there will be a requirement to pay any group of providers more money, that’s got to reflect itself in the premiums eventually,” Holt said.

The payment parity bill was approved by the House health committee early this month and sent to the House floor for a vote. But lawmakers opted to kick the bill to the Rules committee, essentially keeping the bill alive till the end of the session without forcing lawmakers to make a decision on the matter.

“There’s a lot of people who don’t want to vote no, because they like supporting the nurses, but they also don’t want to vote yes, because they want to support the doctors,” said Rep. Mitch Greenlick, (D-Portland), who backs the bill.

That leaves lawmakers and proponents of the bill a week to resolve concerns over the bill, including whether lawmakers should be involved in regulating payment rates for private insurance companies.

“I have somewhat of a dim view of the legislature’s ability to micromanage the market and actually achieve a good outcome,” said Rep. Jason Conger (R-Bend), a vocal critic of the bill. “With that said, I think the state does have an interest in making sure the market is shaped in such a way that primary care is available for its citizens.”

Conger thought that perhaps an interim workgroup might be a compromise solution, allowing all sides to find an equitable solution that avoids many of the thorny issues raised.

That could, however, open the door for more categories of providers, such as physician assistants, to ask for payment parity as well.

“There’s a long line of other folks who would like to get paid just like physicians,” Holt said.

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