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February 2016

Teresa D. Miller, Commissioner
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120

Dear Commissioner Miller:

The Pennsylvania College of Emergency Physicians (PACEP), representing over 1,600 member physicians from across Pennsylvania, appreciates the opportunity to submit comments regarding the department's proposed draft legislation on balance billing dated January 19, 2016.

Our Emergency Departments are the health care safety net for all Pennsylvanians. They are the only locations where anyone can receive care regardless of their condition or ability to pay. Emergency physicians represent 4% of the physician workforce. We provide 28% of all the acute care visits. We provide 50% of all care to Medicaid and CHIP participants. We provide more charity care than any other specialty and provide 67% of all uninsured care. We need fair reimbursement so we can be there when you have your emergency.

We champion the rights of patients every day, including the **right to unfettered access to emergency care** and the **right to fair coverage** from insurance companies. Unfortunately, in recent years, insurers have dramatically increased deductibles and shifted costs to patients. Many Pennsylvanians choose "high deductible" plans. These are often associated with narrow networks with attractively low premiums that hide high out-of-pocket costs when patients visit the doctor. They are designed to discourage patients from seeking care. Furthermore, 80% of ED physicians surveyed have reported they have seen patients who suffered consequences as a result of delaying care, secondary to the fact they have higher out of pocket costs.

Balance billing by emergency physicians is neither common nor does it involve excessive amounts. A survey of claims in Washington State showed that less than three 3% of emergency physician bills involved balance billing. Moreover, the average amount of those balance bills was less than $250. And the number of balance bills in excess of $500 was less than a dozen. This is a far cry from the exorbitantly high figures often cited by the insurance industry.

To better understand the scope of the problem in Pennsylvania, PACEP would like to review all the balance bills from emergency physicians that have been referred to your office. PACEP requests that a thorough and transparent analysis of all surprise bills provided by the insurance companies be conducted by the Insurance Department to ensure a proper understanding of the cause and extent of these surprise bills before any legislation is introduced to address the issue. We anticipate that an objective analysis will find that the vast majority are due to insurance policy provisions (high deductibles or co-payments) rather than out-of-network billing by non-participating providers.

Wherever there may actually be exorbitant balance bills from emergency physicians that are clearly far out of line with average charges for a given service, PACEP would support responsible action to ensure the patient is held harmless. But sadly, the insurance industry has rejected consideration of such solutions in the numerous states where they have sought to legislatively prohibit balance billing.

Emergency physicians are especially sensitive to the issue of balance billing because we see all patients regardless of insurance status or ability to pay. We take this professional responsibility very seriously, and it is codified in federal law, EMTALA (Emergency Labor and Treatment Act). When a patient requests a medical evaluation from us, we treat them all the same, regardless of insurance status or ability to pay. Out-of-network patients are treated the same and charged in the same manner as in-network patients. There is no difference in care by the physician based on a patient's insurance status. The difference comes when insurers refuse to adequately pay for care provided by physicians who aren't in their network.

Consider this common emergency department scenario: your spouse is having a heart attack and is critically ill. The emergency physician has activated the cardiac catheter lab and a cardiologist is on the way to the hospital to perform an emergent catheterization. Your spouse develops an unstable heart rhythm and becomes unresponsive. He/she is shocked back to life by the emergency physician. Your spouse is now awake and still having chest pain. The case manager informs you that you are out-of-network and may be stuck with large medical bills, if not covered by your insurer. Do you want to transfer your spouse to another hospital or waste time tracking down an in-network provider? Of course not. The cardiologist performs the procedure and the patient recuperates in the ICU, where a critical care intensivist will care for him or her. **Physicians and hospitals are the only solution to any emergency medical condition.** Do you feel it would be appropriate for the patients' insurance to refuse out-of-network bills from these physicians who rendered such care? It would be shameful to blame physicians when it is the insurance carrier who refuses to pay the bill.

Emergency services are fundamentally different from other episodes of health care. By definition, patients come to us in times of crisis. We, as emergency physicians, do not recruit patients based on ability to pay or even look at insurance prior to providing care. Emergency physicians lack the leverage in negotiating with insurers that all other specialties have. This allows insurers to pay whatever amount they unilaterally decide to pay to emergency physicians. Then when physicians try to recoup payment for their services, the insurers claim unfair billing practices from the physicians. An objective analysis will demonstrate that it is insurance companies that are acting unfairly. **By pursuing a prohibition against balance billing, without any provision to truly ensure fair payment for providers, they seek to assume complete and total ratemaking authority in deciding how much emergency physicians will be paid.** Unfortunately, the proposed remedies offered in the department's draft legislation do not offer the fair payment safeguards that must be included in order to avoid this scenario and protect Pennsylvanians and Pennsylvania's health care safety net, the emergency department.

Specifically, PACEP opposes the proposed solutions in Section 303 for the following reasons:

- Paragraph D, Option 1a states that "the health carrier shall pay to the emergency care provider the lesser of (1) the provider's charges or (2) XXX% of the amount Medicare would reimburse for such services." Medicare was never meant to reflect fair market value for medical services; rates are set based on political calculations and federal budgetary requirements. The lack of growth in

Medicare reimbursement would not be acceptable in any other industry. A payment system that is already inadequate will become more so.

- Option 1b states that "the health carrier shall pay the emergency care provider the greater of (1) the median amount the covered person's health care plan would pay for such service if rendered by an in-network provider or (2) XXX% of the amount Medicare would reimburse for such service." We are concerned that if all out-of-network payments are tied to an insurer's in-network payment, insurers will be incentivized to lower in-network rates. What's to stop them, given that emergency physicians will care for all patients regardless of insurance network or status? If providers balk and go out of network, the most they could get paid would still be the lower in-network rate.
- Option 1c states that "the greater of (1) the amount negotiated with In-Network Providers in the Service Area for the Emergency Service furnished, excluding any In-Network Cost-Sharing amount. If there is more than one amount negotiated with In-Network Providers in the Service Area for the Emergency Service, the amount shall be the median of these amounts, excluding any In-Network Cost-Sharing amount. In determining the median, the amount negotiated with each In-Network Provider shall be treated as a separate amount (even if the same amount is paid to more than one Provider). (2) The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq.) for the Emergency Service, excluding any In-Network Cost-Sharing amount." We would oppose both of these options, as already outlined above, as grossly inadequate and placing undue ratemaking authority with insurance companies.
- Option 2 for emergency and non-emergency services would allow providers to bill a percentage of Medicare payment that may or may not be acceptable to the insurer or bill for an amount certain that the insurer may or may not deem acceptable. Failure to reach agreement would result in the instigation of the dispute resolution process detailed at length in Section 304. Insurance companies work hard to save money for the company; they devote significant resources to dispute of bills. Hospitals and providers want to take care of the next patient. We are not set up for continuous arbitration of payments for care already provided. We demand a solution that will provide the patient fair coverage, give providers fair reimbursement, and require minimal arbitration. As noted earlier, most emergency department bills are not large and therefore it doesn't make financial sense to arbitrate them individually. This system of arbitrating each individual disputed claim plays right into the insurers' hands. PACEP requests that any legislation includes language that providers can batch or bundle similar claims during arbitration.

PACEP wants legislation that works. We believe that legislation enacted in Connecticut and Texas provide the parameters for meaningful and fair resolution for all parties, while protecting patients and the emergency care system. Using these laws as a model, PACEP would respectfully propose the following solution:

- No insurer shall require prior authorization for rendering emergency services to an insured.
- No insurer shall impose, for emergency services rendered to an insured by an out-of-network health care provider, a coinsurance, copayment, deductible, or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible, or other out-of-pocket expense that would be imposed if such emergency services were rendered by an in-network health care provider.
- The insurer must reimburse the provider **the greatest of**: 1) The amount that would have been paid to an in network provider; or 2) the usual and customary (UCR) amount. UCR is defined as "the 80th percentile of all charges for the particular health service performed by a heath care

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provider, in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization, specified by the insurance commissioner. Such organization shall not be affiliated with any health carrier."

We believe that the methodology proposed above only should apply to out-of-network balance bills above $800 per CPT code. Otherwise, emergency physicians should be reimbursed by insurers for full charges given the crisis nature of emergency services.

I think all would agree that a methodology for reimbursement of emergency services that eliminates most disputes while promoting transparency and fairness is preferable for patients, physicians, and insurers. We acknowledge that there is a shortage of physicians in the state. We hope to ensure that any healthcare legislation that is passed will not worsen our current physician shortage. We are happy to see that the Insurance Department recognizes the importance of this issue and its impact on the ongoing health of our health care system. **You have an opportunity to take meaningful and equitable steps to sustain our emergency health care system and protect the interests of patients.** We ask that the department engage in additional detailed study of this issue to ascertain the true nature and magnitude of the problem before acting. If legislative action is then deemed appropriate, we strongly encourage development of an out-of-network payment plan that requires no prior authorization for emergency services, does not penalize patients for seeking emergency services at the most appropriate facility, defines the methodology for reimbursement, including usual and customary charges, and requires payment for all charges under $800.

Thank you for your consideration.

T. Fijewski

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*Sources available upon request.

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