
From: Craig Price
Sent: Thursday, February 18, 2010 5:48 PM
To: Jordan Estey
Subject: RE: "Emergency" care definition

Jordan,

In addition to the response we sent yesterday regarding your specific question about definitions of emergency care, ACEP also would like to provide additional feedback on a few other emergency care issues contained in the NCOIL model bill or included in the comments that various groups have provided to NCOIL.

Since Section 6 of the model legislation was not covered in the last conference call, ACEP would also like to call attention, once again, to the suggested changes to this section which we feel are very important. Without these changes in language, the provider's disclosure requirement would apply to bills that do not involve 'balance billing'. Without these changes, the disclosure would also apply to bills sent to patients when the provider may not even know whether the patient has health plan coverage, whether the plan was willing to pay the provider's claim in full, or what payment the plan was willing to make. Disclosure in these bills per Section 6 should really only apply when the provider is seeking payment from the patient of the difference between the plan's allowable payment and the provider's charges (excepting deductibles, co-pays, or coinsurance payments).

ACEP would also like to take the opportunity to provide feedback to NCOIL legislators on some of the comments from selected stakeholders responding to the proposed NCOIL model legislation. Some of these comments really deserve to be considered in light of this feedback.

Comments of the Louisiana Department of Insurance

Regarding the Departments suggestion to include the following

Comment [JE4]:

Section 4.1 Prohibition of Balance Billing

A health benefit plan is obligated, through either a direct contract with the facility or direct contracts with facility-based physician, to pay for covered health care services, including, but not limited to all reasonably anticipated ancillary covered services rendered in connection with treatment to its enrollee at that facility. In the absence of direct contracts with a facility-based physician, the health benefit plan shall, in its direct contract with the facility, arrange for such payment to the facility-based physician and shall include a provision in the direct contract that prohibits the facility-based physician from balance billing, attempting to collect from, or collecting from the enrollee any amount in excess of the payment received from the health insurance issuer other than those representing the enrollee copayment, deductible, coinsurance, or amounts due for noncovered health care services. This provision of law shall supersede existing provisions or laws to the contrary.

In this proposal, the Louisiana DoI suggests that hospitals be charged with the duty to require all facility-based physicians who are contracted to provide services at the hospital (presumably through agreements to staff the hospital's various clinical departments) to accept as payment in full whatever the health benefit plan determines to be the reasonable value of the physician's services. This is nothing less than a license for health benefit plans to set physician fees, a license to steal. This would undoubtedly perpetuate and exacerbate the systematic underpayment of hospital-based physician claims, resulting in the unconstitutional taking of physician services, and would engage the hospital as a co-conspirator in the violation of the physician's rights. It would effectively make these physicians the indentured servants of every health benefits plan. Surely, the Director of the DoI understands that these plans, motivated by the desire to minimize their costs and maximize their profits, would take advantage of their unhindered ability to underpay these claims, and use this ability as leverage to force these physicians to accept deeply discounted below market value contracted rates.

This in turn would result in the total dissolution of the fair market for the services of these physicians, and eventually disrupt not only the supply of these physicians in those markets that adopted this bizarre strategy, but also the ability of the plan's enrollees, and in fact everyone's ability, to access care from these providers. Hospitals, many of which are already in deep financial straits themselves, in an effort to ensure the ability of hospital-based physician groups to recruit and retain these physicians in light of this disrupted market, would be forced to spend millions of dollars to subsidize the revenues of these hospital based physician groups. Thus, the Louisiana DoI's recommendation, if adopted, would transfer hundreds of millions of dollars from a cash-strapped hospital industry and from hospital based physician groups struggling to meet their EMTALA-obligated mandate to care for the uninsured, to a profit-engorged health insurance industry.

Comments from Families USA

Regarding the organizations recommendation #2:

- 2) The legislation should hold patients harmless for charges exceeding their copayments when they need and use emergency care. NCOIL should give legislators point legislators to alternatives for reaching reasonable payment rates for out-of-network services in those cases, such as the following:
 - a. Require payment at a reasonable and customary value, as has California, and prohibit providers from balance billing;
 - b. Establish payment rates based on Medicare rates (or a percentage above Medicare rates), as has Maryland; or
 - c. Establish an arbitration process between plans and out-of-network providers, as has Delaware.

The 'solutions' to the balance billing / fair payment issue listed above are at best incomplete, and at worst a prescription for the unraveling of the emergency care safety net. A requirement for plans to pay non-contracted emergency care providers at the reasonable and customary value of their services is a valid approach only so long as: a) there is a clear definition of this value, b) this fair payment rate is a reflection of the market value of these non-contracted services, c)

there is a fast, fair and cost-effective way to resolve disputes over payment, d) nearly all claims are paid at this fair payment rate, so that few payments or charges need be disputed, and e) there is aggressive enforcement of these rules by appropriate regulatory agencies. None of this has been established in California.

Medicare rates are discounted rates for the care of the elderly and disabled. Medicare rates are not a reflection of the fair market value of non-discounted services to the commercially insured, and a reflection of government budgetary constraints. Several courts, including the CA Supreme Court in the Prospect case, has repeatedly stated that Medicare (or even some percentage of Medicare) should not be held as a standard for non-contracted commercial services.

Arbitration processes may work for disputes over fair payment of very large claims, but they fail as a mechanism for the resolution of large numbers of relatively small claims disputes. Neither providers nor plans should be expected to take millions of claims through a dispute or arbitration process to resolve the questions of fair payment or reasonable charge.

Comments from America's Health Insurance Plans

AHIP points out that 'protecting consumers from run away charges billed by some out-of-network providers is an important responsibility' that has been ignored. ACEP has been among the first to acknowledge that some physician's charges are excessive, and we have proposed solutions to the issue of balance billing and fair payment that would address both the occasionally excessive charges of some physicians and the systematic underpayment of provider claims by most health plans. However, the plans have rejected such solutions, promoting instead an across the board prohibition of balance billing with no fair payment provisions. This would seem to suggest that the plans believe that excessive physician charges from non-contracted providers are not the exception, but the rule. ACEP believes that most non-contracted hospital based provider charges are reasonable and fair, and should be paid in full.

AHIP also suggests initiatives to strengthen the incentives for providers to participate in their networks. ACEP believes that there are plenty of incentives for hospital-based providers to contract with health benefit plans, and some of these incentives are frankly coercive; and consequently the vast majority of claims from hospital-based providers are already covered under contract. Typically, when hospital-based providers chose not to contract with a health benefit plan that is networked with their facility, it is because the payment rates offered by the plans are woefully inadequate; and this in turn is often a reflection of the plan's ability to significantly underpay non-contracted provider claims and dump the burden for paying the unpaid balance on their enrollee.

Thanks for requesting our assistance with the prudent layperson issue, and we hope our other comments will be given due consideration as well.

From: Craig Price
Sent: Wednesday, February 17, 2010 5:20 PM
To: Jordan Estey
Subject: RE: "Emergency" care definition

Jordan,

47 states (as well as federal laws dealing with EMTALA and Medicaid managed care programs) have some version of the "prudent layperson" standard for defining emergency care or an emergency medical condition. While the exact language may vary a little from state to state, the prudent layperson standard defines emergency services as:

"those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- (1) Placing the patient's health in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part"

Prudent layperson language was adopted by states dating back to the early 1990's as a means of ensuring that patients are not discouraged from seeking emergency care when they believe that they may be facing a real health emergency...and that insurers could not subsequently refuse to pay for emergency services in cases where patients reasonably believed that they may be facing a health emergency, even though the final diagnosis may reveal that there was not a life-threatening or other serious medical condition. (For example, patients with chest pain who may reasonably fear that they are having a heart attack, should not be discouraged from seeking emergency medical care and should not have to worry that insurers will refuse to pay for services even if the cause of the pain is later discovered to be not of a serious nature.)

Please let me know if you need any additional information.

-Craig

Craig Price
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American College of Emergency Physicians