**From:** Cheryl Parcham
**Sent:** Thursday, February 25, 2010 2:22 PM
**To:** Jordan Estey
**Subject:** follow up on emergency room balance billing

Per our conversation, I'm writing to further explain my concerns about exempting emergency services from NCOIL's balance billing model act. As drafted, your model bill is about disclosure that a patient might be balance billed, but it does not prohibit balance billing. It is not clear to me whether you are carving out emergency services because patients should never be balance billed for them (which we would support) or whether you are carving them out because you believe that though patients may be balance billed for emergency service, it would be impossible to provide them with disclosures. In any case, since balance billing in emergency settings has been a major problem for consumers, here are the protections I would advocate:

1) The definition of emergency services proposed by the American College of Emergency Physicians is fine.

2) HMOs and PPOs should be required to contract with sufficient provider networks such that members have access to in-network emergency providers at every facility within the plan's service area, and certainly in every contracted facility, 24-hours per day. (I do not have California's latest network adequacy standards but you might check to see if their new law addresses this. Their prior law already had some helpful general language about network adequacy at Ca Health and Safety Code 1367: "All services shall be readily available at reasonable times to each enrollee.")

3) For patients that must use out-of-network providers in an emergency (for instance, because they are traveling or because the plan was not able to meet the above network adequacy standard), HMOs and PPOs should have payment procedures that hold patients harmless for charges above the plan's copayment or coinsurance amounts, and licensed providers should be prohibited from balance billing. Similarly, when a network hospital assigns an out-of-network provider without patient advance knowledge and consent (for example, in the midst of surgery), patients should be held harmless for additional out-of-network charges. As I noted in my testimony, you could provide legislators with several alternatives for determining reasonable provider reimbursement in these cases (payment based on reasonable and customary value, payment based on Medicare rates or a percentage above Medicare rates, or an arbitration process.) Health plans might be required to have a dispute resolution mechanism for noncontracting providers to resolve billing disputes with the plan.

4) Since the insurance regulator will not have jurisdiction over provider behavior, you may need to use other tools - such as provider and hospital licensure - to enforce a prohibition on balance billing of emergency services.

5) Consumers should still receive notice (disclosure) when an emergency service provider is out-of-network, including notice about the procedure the plan and provider will use to resolve the bill and hold the consumer harmless for charges, and about any appeal rights in the event that the consumer is balance billed. Under EMTALA, emergency providers cannot delay treatment to obtain payment information, but it is still appropriate to provide disclosure after the patient is stabilized and when the facility is gathering payment information from the patient.

Some state laws that you might be able to pull language from include California Health and Safety Code 1371.4; Colorado revised statutes 10-16-7042, and Delaware Code 18-3565.

I am copying Kevin Lucia at Georgetown Health Policy Institute who also has done a lot of research on balance billing and may have further input.

Sorry I will be unable to attend your meeting in South Carolina this weekend, but let me know if there are subsequent opportunities for consumer input.

Cheryl Fish-Parcham
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Families USA