American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

November 2, 2015

The Honorable Roger A. Sevigny, Commissioner
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

The Honorable Mike Kreidler, Commissioner
Office of the Commissioner of Insurance
Insurance Building, Capitol Campus
Olympia, WA 98504

RE: Managed Care Plan Network Adequacy Model Act

Dear Commissioners Sevigny, Kreidler, and Members of the Health Insurance and Managed Care (B) Committee

The American College of Emergency Physicians (ACEP), representing over 34,000 member physicians across all 50 U.S. states and territories, appreciates the opportunity to comment on revisions to the above referenced model act. We appreciate the extended and extensive effort by regulators and interested parties that has gone into revising this model, and we appreciate that in many respects the work that has been completed by the Network Adequacy Model Review Subgroup has resulted in substantial improvements from the earlier model. Nonetheless, we will restrict our comments to one specific area – newly created Section 7 ("Requirements for Participating Facilities with Non-Participating Facility-Based Providers") – for which we would respectfully request further consideration.

ACEP understands the interests that have led regulators to address the impact of balance bills on health care consumers. In fact, as we have seen the impact of a variety of trends in recent years on our patients, we have developed similar concerns, with the result that we have questions about the extent to which the increased financial burdens that have been placed on patients as the consequence of changes in the health care financing system are resulting in them declining to receive or delaying medically necessary care. While there is a public attempt to claim that such financial burdens result from unexpected billings from out of network providers, upon closer examination it becomes clear that patients more often are experiencing financial difficulty as the result of a combination of other factors mostly outside the control of physicians. Higher deductibles, copayments, and out of pocket maximums financially strap our patients even before they end up receiving a bill, because their health plan also fails to meet the covered person's expectation that the plan will make adequate payment for

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covered services to the emergency physician. In the past, balance bills were rarely a problem in emergency medicine because insurers negotiated in good faith to create adequate networks for their consumers and offered fair reimbursement to physicians, whether inside or outside their networks. Most insurers still do. However, the current issues of balance bills in the world of emergency medicine largely result from the failure of some insurers to negotiate in good faith to bring physicians in network and to offer fair payment to physicians. Having created the problem, they wish to look to legislators and regulators to solve it.

It should be noted that emergency physicians, in meeting our obligations under federal law, ensure that patients presenting at our departments with a reasonable belief that they have an emergency condition receive a diagnostic exam and stabilizing treatment without regard to their ability to pay. This means that we provide care to uninsured patients from whom we never receive any payment, as well as care for patients receiving coverage under government programs, even when we consider payment for such services to be inadequate. We also recognize the importance of emergency physicians to our health care safety net, which requires us to be prepared and available to treat any patient that comes in the door for whatever emergency injury or illness at any time of the day or night. We would respectfully suggest that a payment scheme that additionally results in inadequate payment for insured patients and disincentivizes insurers from fair negotiations endangers this safety net. Of note, emergency physicians provide far more uncompensated care than any other physician specialty. While only 4% of physicians, they provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients.

With that perspective in view, we would suggest that regulators consider the following approaches with regard to Section 7 of the Model Act:

1. Regulators should consider removal of Section 7 in its entirety from the Model and allow the issue of out of network reimbursement to be resolved by the states in ways that are consistent with the needs of patients, health care providers, and health plans in their individual states.

In support of this approach, it can be argued that the question of whether health care providers should have the right to bill those who use their services for amounts not covered by their insurance issuers is a social policy question outside the ordinary scope of insurance regulation. As such, it is a matter not only outside the scope of this particular model act, but outside the scope of insurance regulation such as is normally promulgated under the auspices of the NAIC. It should be noted that by eliminating balance billing and suggesting benchmarks for determining reimbursement, that the NAIC is essentially engaging broadly in rate setting without having performed the necessary

independent data collection and analysis that would justify such far reaching social policy changes. As such, the NAIC should consider removal of the Section. A drafting note could encourage states to consider the financial impact of network adequacy and narrow networks on health insurance consumers in their states.

It should also be noted that removal of Section 7 would promote the goal of uniformity in insurance regulation across states. Proposed Section 7 will be hotly contested in every state in which it appears, and this will without doubt result in a variety of amendments. To the extent that the NAIC wishes to promote uniformity in insurance regulation, Section 7 works against that goal.

2. Regulators could retain Section 7, but revise it to remove the restrictions on billing and receiving reimbursement from those receiving out of network services. If language related to payment benchmarks for presumptively fair payment amounts is retained, such language should be revised to include benchmarks that will result in a fair payment standard.

Permitting out of network physicians to balance bill helps to ensure that insurers have incentives to make fair payment for claims, as well as to seek to bring physicians in network. A statutory scheme that allows for payments that are too low would mean that there is no incentive for insurers either to pay fair amounts or to seek to include emergency physicians in their networks.

The benchmarks currently referenced in the model are inadequate. The first benchmark is the carrier's contracted rate. When insurance carriers contract for reduced rates with providers, they gain from the health care provider agreement to be paid at a discounted rate in exchange for consideration – such as steerage of patients. That the model would provide for payment at a contracted rate in spite of the fact that the insurer is offering nothing in exchange is unjust and clearly eliminates the insurer's incentive to contract.

The other benchmark is an unspecified percentage of Medicare, with state legislatures left with the task of determining the proper percentage. While using Medicare allows for simplicity, members of the committee are aware that Medicare amounts result largely from political calculations based on federal budgetary requirements. As such, Medicare is not properly constructed around establishing appropriate reimbursement for care. While physicians are grateful for the SGR "doc fix" that occurred in the past year, that issue, and the length of time that it took to resolve it, amply illustrates the inadequacy and potential for trouble that comes with using Medicare as a benchmark for a statutory scheme for private insurance. In fact, while the medical community has celebrated the ending of SGR that has brought a measure of stability to Medicare reimbursement, it might be noted that "stability" involves a lack of growth in payment that would not be acceptable in any other

business or industry. In short, a payment system that is already inadequate will become more so over the next decade. Even with legislators using multipliers, it is not an appropriate statutory benchmark for private insurer reimbursement

In determining a proper mechanism for reimbursement, it should be noted that insurers have long advocated the use of usual and customary reimbursement (UCR) schemes. Traditionally, health care providers have questioned the use of UCR because such reimbursement methodologies were lacking in transparency and under the control of insurers who refused to disclose the basis for their calculations. However, as the result of the settlement of litigation in New York, a transparent charge data base now exists that can be used as the basis for determining fair reimbursement. While we would not suggest statutory language specifying that particular data base, we would contend that it or any future competitor that has comparably comprehensive data, quality, independence from the control of either providers or payers, and transparency would give policymakers an ideal mechanism for designating fair reimbursement at an appropriate percentile of the data base. For more information about the one data base currently known to possess these characteristics, regulators can consult FairHealth.org.

In the development of the revision of the model act, the subgroup considered language that would make use of this UCR mechanism for determining a fair payment amount, but they relegated it to a drafting note. We would suggest that using an appropriate percentile of the Fair Health Data Base, or similar transparent data sources that may arise, provides an ideal opportunity to address billing and payment in a manner that meets the needs of health care providers and insurance carriers, with the result that patients are once again unburdened by this financial consideration. As such, this UCR methodology should be included in the text of the model law.

Health plans opposed to the use of this UCR mechanism have contended that it can be manipulated into an upward spiral. While that seems unlikely given that it would require coordinated manipulation of billions of transactions from a large number of provider entities, policy makers concerned about such an eventuality could resolve it by utilizing the data base as of a date certain and with an appropriate update based on medical inflation. Frankly, insurers mainly seem to oppose UCR because they no longer control it. We see independence and transparency as paramount to ensuring that payment based on statutory mechanisms is to be fair for all parties.

3. If regulators retain the current draft's prohibition on balance billing, it is even more crucial to alter the language to include an appropriate mechanism for fair payment.

If this is to be the policy expressed in the NAIC model, we would contend that it is even more important to utilize the UCR language discussed above in order to ensure an appropriate mechanism for determining fair payment to health care providers.

In addition to the other considerations outlined above, we would point out that because UCR done in this manner provides a transparent, mutually agreed upon mechanism for determining payment, it largely renders unnecessary the substantial alternative dispute resolution process created by the draft model. While the availability of ADR is important if needed, it represents a drain of resources for health care providers, health plans, and for state agencies. Emergency physicians would note that disputes over our charges frequently involve small amounts of money that make dispute resolution processes less than cost effective, even if payment amounts remain consistently unfair. As such, all should agree that a methodology that eliminates most disputes while promoting transparency and fairness should be preferable.

As such, we would urge the committee to consider the importance of this issue on the ongoing health of our health care system. We believe you have an opportunity at least to take steps to contribute positively to the solvency of our health care system while protecting the interests of patients of health insurers. We would suggest that inclusion of UCR in the Model in the manner we have described would be a positive step.

Thank you for your consideration.

Sincerely,

Jay Kaplan, M.D., FACEP
President
American College of Emergency Physicians