Recommendations from the Utah Chapter of the American College of Emergency Physicians on Representative Dunnigan's Balanced Billing Legislation

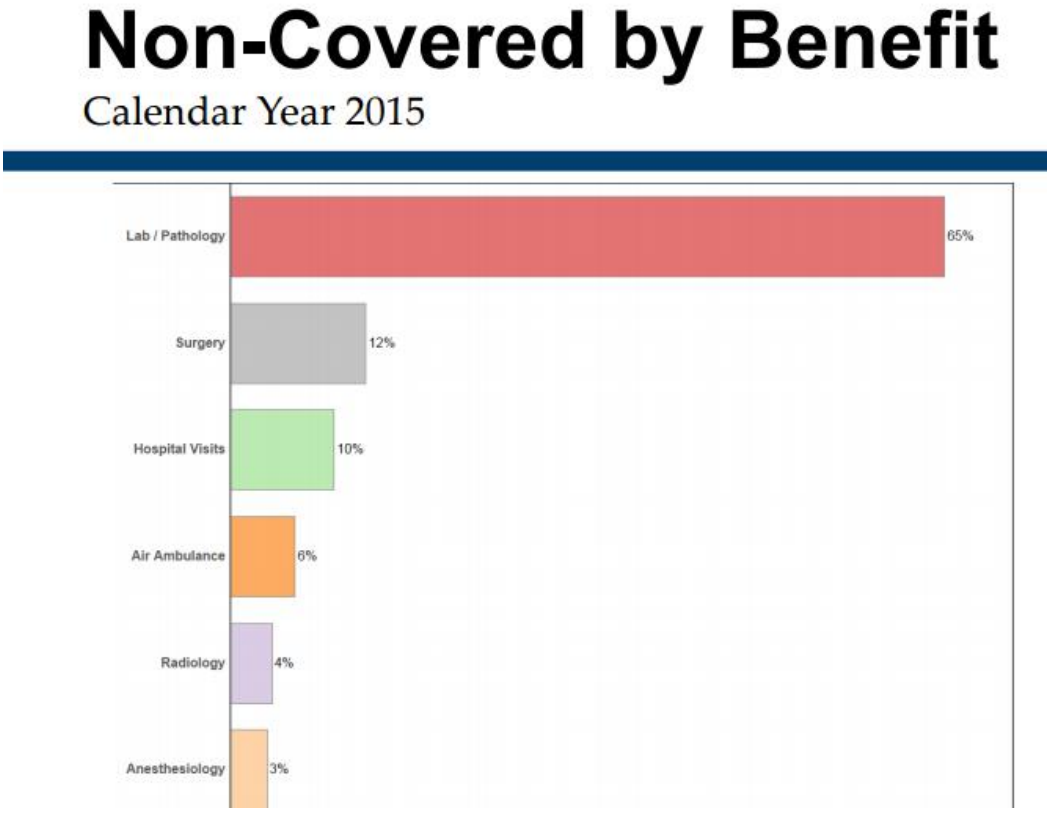
My name is Dr. John Dayton, and I represent the Emergency Physicians practicing in Utah.

Since the implementation of the Affordable Care Act, there have been many changes to healthcare, some positive and some negative.

One of the most concerning changes is that insurance companies have raised their rates, narrowed their networks, and decreased their coverage. Even though all insurers cover emergency care, the amount of cost shifting to the patient in the form of co-payments, deductibles and co-insurance (for both in-network and out-of-network) is mind boggling. Rather than talking about balanced billing, we should be discussion **surprise coverage, or surprise lack of coverage.**

Representative Dunnigan has been working on this legislation for months, and he should be praised for that. There are several problems with this legislation, however.

When I met with Rep. Dunnigan about this legislation, he acknowledged balance bills coming from Emergency Physicians are rare – he knew of **only one such episode**. He has used data and graphs from the Public Employee Health Plan showing the extent of balanced billing in Utah and the associated costs. What is remarkable about this data is that there are several common sources. Most notably, 65% of balanced billing comes from laboratory bills. What is also remarkable is that balanced billing from emergency physicians doesn't happen enough to even make the graph.



- From page 4 of 6C-Insurance Perspective on Hidden Providers (PEHP) used at Health Reform Task Meetings on May 19th

Emergency Physicians work in an interesting atmosphere. We do not choose our patients and they do not choose to have emergencies. We do, however, **take care of everyone** who comes through our doors. If your emergency occurs at 3 AM, on a holiday, or on a weekend, you know as a patient in Utah that you will be able to find care. There are two drivers for this: the first is that we chose a specialty with an ethos of never refusing to provide care. The second is that our care is also federally mandated. Unlike any other medical specialty, our care is required by a law called the Emergency Medical Treatment and Labor Act, or EMTALA.

While we are happy to provide this care, we are also in a delicate position when it comes to working with insurers to set reasonable rates. We have a unique skill set we obtained through four years of medical school and at least 3 more years of 80 to 100 hour weeks as we obtained specialty training in ERs and ICUs. We took out major debt to get this education, and sacrificed (and still sacrifice) time with family, friends, and other opportunities, so that we can take care of the patients in Utah. That being said, our skill set should be valued. It should not be capped or restricted according to the desire of insurers, per pages 13 and 14 of this legislation.

Knowing that we choose to provide the care, and that we are federally mandated to provide care, insurers will take advantage of this opportunity if they are allowed to set rates according to this legislation. This happened with United Health Care, it's happening in California, and it will happen in Utah. Allowing any one industry to set rates for another is a horrible precedent to set in Utah. This concept is not based in a free market. It is a particularly dangerous precedent to set this session when it involves your health.

Along those lines, if an insurer provides inadequate coverage, it is the insurer's responsibility to make that known to the patient, not the patient's HMO, as per lines 371-372. When I am seeing a patient in the ER with a heart attack, stroke, or traumatic injury, delaying their care to discuss coverage would be unethical and dangerous. If you are a patient with health insurance, emergency care should be covered.

I met last week with several leaders from other medical specialties and chief medical officers from some of Utah's hospital groups. We are also uniformly disgusted with aggressive billing practices. I faced this as a parent for a child that was delivered in an out-of-network hospital and required ICU care. It was a wonderful experience to have my father deliver one of my sons. It wasn't great to have the associated ICU bills associated with his care.

We believe many **"balanced bills" actually represent surprise bills,** and are the result of decreased coverage and higher deductibles. That being said, we acknowledge there are some physicians who are guilty of aggressively billing out-of-network patients.

Rather than moving forward with the wrong solution for a recognized problem, we recommend that any legislation addressing balanced billing utilize the following standards:

- **Focus on the problem:** Per PEHP data, out-of-network laboratory bills represent the lion's share of balanced billing in Utah. By Representative Dungan's own admission, he is aware of only one case of balanced billing by an emergency physician. So why is emergency medicine the focus of this legislation and not out-of-network lab costs? Because of the unique nature of federally-mandated care provided by Emergency Physicians, other states have exempted emergency physicians from balanced billing legislation. They recognize that insurers should cover emergency care wherever the emergency occurs. Again, why is emergency care the focus of this bill?
- **Use a non-biased resource:** Billing standards need to be set by a non-biased group – not the hospitals and not insurers. Insurers set the **Usual Customary Rate** and using this standard is Rep. Dunnigan's most recent iteration of the bill**.** This rate is the result of talks between physicians and insurers, but this number is ultimately set by the insurers. Similar to Connecticut's recent legislation,

out-of-network reimbursement should be tied to a **Minimum Benefit Standard**. A non-biased national billing database like **FairHealth** should be used. Concerns have been expressed that Fair Health does not have sufficient data for Utah, but they have assured us that they have records of more than 50% of payments for health care in Utah. They also use a regional standard, so Utah rates will not be comparable with higher prices seen in San Francisco, Boston, or DC.

- **We need data:** Despite our requests, we have not received raw data regarding where these numbers are coming from. Is this a result of a major cost shift to the patients by the insurers or the physicians? Our major insurer in Utah does not balanced bill.

It is our recommendation that no legislation addressing surprise billing be passed this year. We need more time to evaluate these bills. Are these surprise bills related to cost shifting from insurer to patients or are they a result of balanced billing? We recommend that the issue be addressed by interim study and addressed in a future session.

Summary:

- Because of federal law, Emergency Physicians have **no choice** regarding who they will treat.
- Patients have **no choice** about when and where an emergency occurs in their lives.
- This bill gives **choice** to only one group: the insurance companies. It gives them the choice not to pay Emergency Physicians the recognized fair market payment for care. These numbers are transparent, unbiased, and available through the FairHealth database.
- The bill seeks to cap payment for a portion of that value. We will always provide **100% of the care** our patients need. This should not be used as an excuse to cap our rates or pay us **a portion of that value**.
- We recommend using a non-biased, regional reference like Fair Health to set out-of-network rates. We need data and further study of this issue to work together to find a solution that works for patients.