American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Emergency Department EDPMA Practice Management Association

Advocating for a Minimum Benefit Standard (MBS) Linked to the 80th Percentile of a FAIR Health-Type Usual & Customary Charge Database

An Information Paper

Introduction

Over the past few years, numerous pieces of state and federal legislation have been introduced that address regulation of out-of-network billing for emergency services. While no two pieces of legislation are identical, the basic provisions usually call for a restriction on balance billing and include some form of minimum benefit standard that insurers must meet for emergency services. The insurance industry, through their well-resourced lobbying mechanisms, has aggressively advocated for extremely low minimum benefit standards. Via skillful use of the media, and direct support of legislators and regulators, insurers attempt to demonize emergency providers, when, in fact, their unstated goal is to improve their bottom line. Physicians who provide emergency services have organized to fight these unscrupulous insurer attacks on fair coverage. By advocating for a fair minimum benefit standard, emergency providers have taken a leadership position in reducing patient financial liability, while at the same time preserving the financial underpinning of emergency care. The emergency provider community has coalesced around supporting a minimum benefit standard set at the 80th percentile of FAIR Health's usual and customary charge database. This strategy paper offers a roadmap for emergency providers to help effectively advocate for a minimum benefit standard that preserves our emergency care system.

Background of OON Legislation

Discussions regarding out-of-network (OON) legislation involve much more than simply "OON billing". The term "OON billing" does not fully identify the causes giving rise to, and the scope of, the varied underlying concerns. The complex issues associated with OON services provided in an emergency medicine (EM) context include: the extent that emergency department (ED) services are covered under the patient's insurance plan; patient education of what is, and is not, covered, and at what reimbursement rates; the legal obligation of EM providers to render care in an ED; the cost associated with rendering that emergency care; and the fair payment that must be made to compensate the providers for that care. Accordingly, there is a larger context, and discussions solely focusing on the billing of the underlying ED services do not appropriately capture the fact that OON concerns involve the relationship of three inextricably, interrelated parties - the provider, the payer, and the patient. Therefore, we will globally refer to the issues and concerns stemming from a patient receiving OON services from an emergency medicine provider as "OON concerns."

The move to investigate, and ultimately legislate, OON concerns brings into focus the complex reimbursement regimen at the heart of the U.S. health care system. Historically, insurers have established limited networks of providers to leverage more favorable (lower) payment rates for health care services. Today, there are an ever-increasing myriad of insurance product designs that complicate the reimbursement landscape, such as high deductible plans, and tiered and narrow networks that involve higher out-of-pocket costs for consumers if they see providers that are considered as being in a less preferred tier or OON. This can result in increased deductibles and/or copays for consumers. Unfortunately, consumers buying these high deductible plans because they are attracted to their lower premiums, often lack the financial means to meet their "patient responsibility" particularly regarding unexpected emergency services.

Within this complex regime, emergency medicine physicians are unique because they are required to treat any patient presenting at a hospital to evaluate for a possible emergency medical condition, regardless of the ability of the patient to pay, under the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA). Due to the volume of uninsured and underinsured patients that emergency medicine physicians treat, and their role as a 24/7 safety net provider, EM physicians must receive fair payment from insurance companies for the services they render.

Further exacerbating these concerns are the frequently referenced "examples" where a patient is treated at a hospital that is in-network, but where the emergency room providers are OON. In recognition of this unique scenario, federal and state laws have been enacted with the goal of protecting consumers from "surprise bills." Any characterization of an alleged patient "surprise bill" is a payer derived concept and misleading phrase that misses the mark. If there is truly any "surprise," it lies in the patient's realization that he/she paid for insurance that only covers the rendering of services in certain facilities and, if rendered outside of these facilities, he/she may personally be responsible for paying a disproportionately large amount of the total bill (ie, a "lack of coverage surprise").

Federal and State OON Legislation

The federal and state protections that have been passed generally require payers to pay OON providers, including emergency medicine providers, a reasonable rate for their services to minimize the cost of covered OON services to patients. Although a laudable goal, these laws have largely been "gamed" by the payers, resulting in greater patient uncertainty, and invariably, greater patient responsibility. For example, the Patient Protection and Affordable Care Act ("PPACA") mandated that insurers pay emergency service providers the greatest of three rates. Although there is some ambiguity in the language of the law, the clear intent was to prevent payers from imposing greater financial burdens upon consumers by paying an artificially low amount to OON providers. This, however, has not been the reality of how this law has played out.

Additionally, many states have adopted various regulatory schemes that attempt to minimize OON concerns. Inevitably, these laws strive to identify certain rates that are "reasonable", limit the provider's ability to seek compensation in excess of these rates, and provide a dispute mechanism that can be used.

Minimum Benefit/Payment Standards

We believe that it is the insurers' use of liberal discretion in calculating the "usual, customary, and reasonable" (UCR) fees that is the principal root cause of the OON Concerns, and the most important problem to be addressed. The "usual and customary" rate used by insurers for emergency services has some inherent limitations, including the lack of provider involvement and transparency in setting rates. Considering these concerns, provider-insurer disputes challenging what is UCR have become increasingly prolific and has led many insurers to propose a percentage of Medicare to be the benchmark in determining payment rates. Although this concept is superficially understandable, the Medicare proxy carries very significant inherent limitations. Most significantly, Medicare rates are a government determined payment rate that is non-negotiable and based upon federal budgetary considerations, thereby lacking any relationship to negotiated fair rate.

Three guiding principles should form the bases for determining appropriate OON payments: (1) payments for OON services should constitute the reasonable value for the services rendered, (2) the payment rates should be established using an unbiased methodology that sets the reasonable value for the services, and (3) providers need to have input into, and access to the methodology used, to ensure payments for OON services are fair and transparent. To that end, a minimum benefit standard (MBS) should be equal to the eightieth (80^{th}) percentile of a geographically comparable database of clinician usual and customary

charges maintained by an independent non-profit organization that is not affiliated, financially supported and/or otherwise supported by an insurer (e.g. FAIR Health).

Background and History of ACEP-EDPMA Joint Task Force

In 2014-15, the president of the American College of Emergency Physicians (ACEP) approached the Emergency Department Practice Management Association (EDPMA) to appoint a joint task force (JTF) with members of both organizations to focus on solutions to two pressing issues: OON and balance billing and Medicaid reform. The work product of the JTF began with an OON White Paper on possible legislative solutions and an OON principles document. More importantly, the JTF gave both organizations a major head start as the rest of the "House of Medicine" came to grips with these issues—and by late 2015 it became clear that Florida would be the next major OON battleground.

In Florida, Speaker of the House (Rep. Corcoran) was the principal advocate in 2016 to address OON balance billing for PPOs (FL had restrictions on balance billing for HMO patients going back to the mid-1990s). Florida ACEP (FCEP) joined with the FL Medical Society and FL Hospital Association toward working on a legislative solution; other FL based specialties attempted to be "carved out" of the PPO restrictions and they were ultimately unsuccessful. FL's new law ultimately applied to "emergency services" and "surprise bills" where the facility was in network (but the physicians were not) and where the patient did not have the opportunity to select an in-network clinician (unanticipated care).

The experiences in FL lead the American Society of Anesthesiology (ASA) to reach out to ACEP's leadership to begin a dialogue to work toward mutually acceptable solutions. The passage in 2015-16 of an OON MBS in Connecticut for EM was an important precedent. These efforts then culminated in an in-person meeting in May 2016 of the leadership of several national physician specialty societies (lead by ACEP and ASA) including ACR (radiology), AAOS (ortho), CAP (pathology), ASPS (plastic surgery), and the AMA. ACEP and ASA leadership also engaged the Under Secretary of HHS at his request to address OON solutions in the spring of 2016. Solutions from the JTF White Paper and the "CT model" with a MBS for OON services were discussed. HHS leadership expressed support for solutions that were transparent and removed the patient from the reimbursement dispute between the clinician and health plan.

In May 2016 at the EDPMA Solutions Summit, leaders of ED groups met to discuss formalizing a separate legal entity to address the OON issues and that other hospital-based specialties should be included in both funding and governance. On June 15, 2016, that concept came to fruition with the creation of Physicians for Fair Coverage, Ltd. (PFC) as a non-profit, non-partisan 501 (C) (4) entity with the goal of passing state based OON legislation along the line of what was outlined in the JTF White Paper.

Creation of the AMA and PFC OON Model Legislation

In conjunction with ACEP's Work Group 2 of the Reimbursement Committee, the ACEP/EDPMA JTF, and PFC, OON model legislation was formally approved by the boards of PFC, ACEP and EDPMA in the spring of 2017. These documents and others were in turn used by the national specialty societies and supported by several major states to present a resolution to the AMA House of Delegates at their May 2017 meeting. It passed, and AMA staff then developed OON model legislation. In November 2017, the AMA promulgated their OON model legislation based on the work product of WG 2, the JTF and PFC.

The PFC OON work group revised the AMA OON model bill and edited the bill to address only the OON issues—leaving the AMA OON network adequacy and assignment of benefit (AOB) provisions for another day. In January 2018, the PFC board formally adopted the "skinny bill" version of the AMA

OON model bill. In February 2018, the EDPMA and ACEP boards also approved the "skinny bill" and ACEP formally approved the revised AMA OON bill for use by the state chapters—whichever they believed best suited their needs. In January 2018, the AMA incorporated some ACEP-suggested changes into their OON model bill that clarified language dealing with MBS and AOBs. The AMA then shared the model legislation with state medical societies with the intent to introduce bills in the 2018-19 legislation session. PFC also shared their model legislation in a select number of states, and as a result, language from the PFC bill became the basis for legislation introduced in Georgia, Kentucky, Oklahoma, and Tennessee during their 2018 legislative sessions.

Advocating for an MBS linked to the 80th percentile of an Independent Database

Emergency services are the jewel of the American health care system. Unfortunately, there are weekly tragic events where emergency physicians are called upon to be ready at a moment's notice for mass casualties. Historically, financial support for 24/7 instant access to EDs has been born by the insurer community and governments. Government support is solely limited to taxpayer-funded hospitals. The cold reality is that commercial insurance payments provide the underpinning of today's emergency medical system, allowing it to maintain the capability to instantly care for America's sick and injured.

Providing emergency care is expensive. Historically, emergency physician charges have been proportionately higher than office based or inpatient medical care. These higher charges are directly related to unique drivers that place downward pressure on reimbursement for emergency services. When determining a MBS for emergency services, legislators and regulators should not ignore four essential areas that affect emergency physicians' charges and collections:

- Uncompensated care – uninsured patients typically have no ability to pay for emergency care
- Low reimbursement carriers – Medicaid, Medicare, Workers Compensation, veteran's care – all reimburse emergency providers at below the cost associated with their beneficiary's care. Combined with uncompensated care, these financial classes typically comprise 65% to 75% of ED patient visits.
- Standby expense – Medical and surgical emergencies do not keep banker's hours. EDs need to maintain full capabilities even in the middle of the night, when patient volume is light or absent.
- Lack of ability to collect co-pays and deductibles – unlike office practices, emergency providers do not collect cost-sharing amounts before treating the patient. There are no wallet biopsies in the ED. Emergency providers collect less than 40% of the patient's cost-sharing responsibility. Office practices collect 100% of cost-sharing amounts.

Problems with an MBS Linked to Allowed Payment Databases

Most insurers and some legislators advocate for an MBS linked to "allowable" payment databases. Allowable databases list the negotiated amount that insurers reimburse providers for individual services. For example, if the physician charges $200 for removing a foreign body from the eye but has negotiated a discounted reimbursement rate of $125 from the insurer, the "allowable" payment is $125. By their very nature, allowable databases only deal with beneficiaries of individual insurance carriers. Allowable databases care not about maintenance of emergency medical services. The Medicare physician payment database is one of the worst examples. Medicare payment rates are solely reflective of federal budget constraints. Over the past 25 years, Medicare rates have decreased by 50% when adjusted for inflation.[1]

1 Comparison of Medicare vs. Inflation 1992-2016

Future Medicare rates will suffer the same constraints.

Unlike office-based medical practices, the above four bullets explain why an emergency service MBS cannot be linked to allowable payment databases. Office-based practices generally have none of the above-mentioned problems with payment for their services. Allowable payment databases are designed by carriers to solely reimburse for medical care rendered to their beneficiaries, usually at the lowest possible cost. They are not designed to reflect the market dynamics necessary to maintain a functional emergency medical system.

Reasons to Incorporate a Usual and Customary Charge Database into an MBS

In contrast, charge databases reflect the totality of the necessary resources to maintain a functional emergency medical system. Revenue generated by charges to commercial insurers, both in-network and OON, are the only method that emergency providers use to cover the cost of care to uninsured and governmental sponsored payers. In addition, benchmarking an OON MBS standard to the 80th percentile of a transparent U&C charge database allows the market to work by encouraging insurers to bargain in good faith when negotiating participation agreements with emergency providers.

An MBS linked to U&C charges incorporates market-based reimbursement dynamics that allow the ED to fulfill its mission of caring for the acutely sick and injured 24 hours a day. In today's budgetary environment state government would be hard pressed to underwrite the necessary expense to maintain a functional emergency medical system, making an MBS based on U&C charges a crucial necessity.

The reason the 80th percentile should be used and not the 50th percentile is because some providers may a have a legitimate reason to charge higher amounts. Emergency providers that staff remote areas may need to charge more to attract physicians to work at hard to staff hospitals. Hospitals in areas with a high proportion of indigent care may need to charge more to pay a competitive salary. Academic centers typically charge more as a tertiary care center since they have clinical expertise in specialized care such as burns, trauma, strokes, etc.

Establishing an MBS for OON Services: Charge Databases

Ingenix Lawsuit

The necessity for an independent charge database was demonstrated in 2009 with the finding of fraud committed by Ingenix, a healthcare information company and subsidiary of UnitedHealth Group. Ingenix was founded in 1996 to collect and analyze healthcare-related data, including billing information. The company maintained a database of claims data, which was used by UnitedHealth in determining UCR payments, and sold to other insurers for the same purpose. New York State Attorney General Andrew Cuomo filed a lawsuit against Ingenix for rigging the database to underpay doctors, stating, "This involves fraud in the hundreds of millions of dollars, affecting thousands and thousands of families…We believe there was an industry wide scheme perpetrated by some of the nation's largest health insurance companies to defraud consumers." Other large insurers were also implicated. UnitedHealth paid over $90 million to settle the lawsuit. As part of the settlement, a portion of that money was used to create a claims database operated by an independent non-profit organization, FAIR Health.

Charge Databases

Several data sources exist for determining UCR. They vary in number of claims, geographical regions represented, types of payers, and the degree to which they represent the population.

As described above, FAIR Health is an independent, not-for-profit organization that was created specifically to fill a need for a source of claims data free from insurer bias. It includes data on 150 million privately insured lives per year. It is a CMS-qualified entity with access to data for Medicare and Medicaid. FAIR Health includes data from 60 organizations, including national and regional health plans and employers, contributed monthly. FAIR Health represents all 50 states and some territories, with data being limited for some geographic areas. Imputation algorithms are used to estimate UCR for these areas. FAIR Health is already in use in more than 14 states supplying data for workers' compensation fee schedules, benchmarks for 80th percentile as UCR for emergency services (CT), and as a benchmark dispute resolution (NY).[2] It is currently the only vendor with data for all states and whose data are being used for reimbursement standards in multiple states.

The Health Care Cost Institute (HCCI) is a non-partisan, non-profit organization with a public-interest mission that receives millions of dollars in revenue from insurance companies each year, primarily United HealthCare, Aetna, and Humana. HCCI data includes 50 million covered lives per year, including privately insured and Medicare Advantage patients. Most data come from Aetna, Humana, Kaiser Permanente, and UHC and is submitted annually. The data include allowed and billed charges. Data are limited in some geographic regions. HCCI is used by many private and public organizations but has not been used for establishing MBS for OON services. However, HCCI lacks the needed transparency and independence from insurers to be a legitimate source of data for an MBS. HCCI also pays Optum UnitedHealth Group to provide back-end IT services, a potential conflict of interest.

Figure 1: Comparison of FAIR Health vs. HCCI

	FAIR Health, Inc.	**Health Care Cost Institute (HCCI)**
Organization	FAIR Health, Inc. NY 2009. Unaffiliated with any insurer or other stakeholder Conflict-free, uncompensated board of directors. Created in 2009 after the NY Attorney General's settlement with United Healthcare over the Ingenix Inc. database. Independent Not-for-Profit, tax-exempt under § 501(c)(3): created as part of legal settlement to establish transparent and accurate source of healthcare cost information for consumers, researchers, policymakers and healthcare industry. Incorporated in statutes, regs and programs: NY, NH, IN, AK, KY, ND, AZ, WI, CT, MN, NJ, PA, MD, MS, and US federal departments and agencies: HHS, GAO, AHRQ, and was recommended by CMS' CCIIO contractor, IMPAQ, as a transparent database. Honors/recognitions include White House, AHRQ, URAC, eHealthcare, AppPicker.	Health Care Cost Institute, Inc., DC 2011. Tax-exempt nonprofit research corporation formed initially by four insurance companies, (three continue to participate, to provide virtual data access to researchers for selected projects.) IRS Form 990 from 2014 shows the following: Schedule B, Schedule of Contributors to HCCI: 1. UnitedHealth Group: $3.59 Million 2. Aetna Inc.: $2.72 Million; 3. Humana Inc.: $1.65 Million; 4. Kaiser Permanente: $350,000 Schedule O: Compensation to the Five Highest Paid Contractors: 1. Optum Global Solutions: $1.050 Million, consulting; 2. Modern Climate: $607,000, website design; 3. Upton Hill, LLC: $538,000, data analysis;
Website	www.fairhealth.org	www.healthcostinstitute.org

[2] FAIR Health State Applications: Workers' Compensation and Other Uses of Data

Data Contributors	Over 60 contributors nationwide - insurers and TPAs.	Three insurers (two of them also contribute to the FAIR Health repository) – Currently Aetna, UHC and Humana
Period of Data Represented	2002 - Present: Widely available in standard products and customized datasets; research subject to security capacity but no substantive or topical restriction/qualification	Available in five-year increments: 2008-2012 or 2009-2013 upon application and approval of project by HCCI
Type of Claims	All types of private insurance – fully-insured, self-insured, group, individual, etc. [Also Medicare – 4+Billion]	Individual-, group-insured and Medicare Advantage.

Two other sources of claims data are Truven MarketScan and Blue Health Intelligence (BHI). Truven reports data on 28 million privately insured lives per year. The data include allowable and billed charges. Most of the data is from large employers. BHI collects data on 60 million privately insured lives per year. It is a for-profit company owned by a group of individual BCBS plans. Neither of these sources license their data for public benchmarking.

State All-Payer Claims Databases

Fifteen states have all-payer claims databases in place and at least eight others are in the process of implementing APCDs. States can mandate submission of data by state law, resulting in consistent, uniform data. However, they may be unable to require reporting by self-insured plans due to conflicts arising with ERISA. Therefore, they may have limited data that is not representative of the entire population.

Nationwide Emergency Department Sample

The Nationwide Emergency Department Sample (NEDS) is part of a family of databases and software tools developed for the Healthcare Cost and Utilization Project (HCUP), which is sponsored by the Agency for Healthcare Research and Quality. NEDS is the largest all-payer ED database in the United States. It contains data for approximately 31 million ED visits per year. It includes charge data for 85% of patients, including Medicare, Medicaid, privately-insured, and uninsured. However, NEDS does not report on professional fee (physician charges) data.

National Council of Insurance Legislators (NCOIL) Recommendation for MBS

The National Council of Insurance Legislators (NCOIL) is a legislative organization comprised of legislators serving on state insurance and financial institutions committees. NCOIL serves as an educational forum for public policy makers and interested parties. The NCOIL model legislation on balance billing sets MBS at the 80th percentile of charges as reported in a benchmarking database maintained by a nonprofit organization and not financially affiliated with an insurance carrier. While the NCOIL model references something like FAIR Health, lending credibility to the 80th percentile of an MBS, other flaws in the model prevent emergency physicians from recommending it as the preferred model legislation.

States with MBS of 80th Percentile of a Charge Database

Most states with balance billing legislation do not define a minimum benefit standard, which leads to

disputes regarding what exactly constitutes fair payment. Notably, New York and Connecticut use the 80th percentile of FAIR Health to define MBS.

New York:

- Identifies FAIR Health as an authorized independent source for health plans to determine usual and customary charges for out-of-network services.
- Plans must seek approval to use a different source.

Connecticut:

- Payment for out-of-network emergency services is defined as the greater of: 1) allowed amount for in-network services, 2) the UCR for such services, defined as the 80th percentile of all charges for the covered service by health providers in the same or similar specialty, from the same geographic region as reported by FAIR Health, or 3) the amount Medicare would pay for the service.

Alaska:

- Alaska adopted the 80th percentile of physician charges for emergency services as the payment standard for emergency services in 2004.

Q & A: Response to Common Criticisms and Questions

Q: Why are contracted rates insufficient to determine OON prices?

- Fair contracting means that both sides will benefit from the contract. For the negotiating process to be fair, both sides must be able to walk away from a bad deal when:
  - Considerations given by providers are not sufficiently addressed
  - Better reimbursement can be negotiated with a new deal
- EMTALA mandated care means that providers cannot decline to see patient. This means that insurers can underpay and still know their patients will be seen – ie, insurers do not need to contract for an adequate network because coverage is federally mandated.
- Allowing insurers to determine OON rates based on contracted rates will give insurers incentive and power to set artificially low contracted rates. This is especially true in an environment where the insurer sets unreasonably high deductibles and is therefore transferring all the risk to the insured. Setting OON payments below contracted rates will allow health plans to cancel contracts that are above average. This leads to a vicious cycle where the average contracted rate will continue to spiral downward.

Q: Why should doctors be unilaterally able to set the price?

- Physicians are not unilaterally setting the payment. Payment will depend on the 80th percentile of UCR. This means that the top 20 percent (outliers) of physician charges are eliminated from MBS consideration.
- Physicians, like any other business, set prices based on the economics of the practice, competition, and business costs.
- Physicians have incentives to have control costs: hospital pressure to serve customers and customer satisfaction. Hospitals do not want doctors who have unreasonable fees.

Q: Will an MBS provide doctors with a financial incentive to increase charges, which will then increase the MBS?

- Physicians have many constraints on what they charge

    - Hospitals with exclusive contracts for hospital-based services want their providers to charge reasonably.
    - Competitor groups and alternative care settings (urgent care, primary care…) provide competition limiting excessive charges.
- Physicians need to have reasonable rates for those without insurance or with a high deductible. Maintaining a good reputation with these patients requires limiting excessive charges.

Q. Will setting an MBS at the 80th percentile of a U&C charge database have a negative impact on state budgets by increasing health insurance premiums for state employees?
- The Alaska DOI imposed an 80th percentile MBS in 2004 by regulation. In CT, the Fair Health MBS was imposed by statute in July 2016. In NY, the Dept. of Financial Services designated Fair Health as an authorized "independent source" for health plans to determine "usual and customary costs" for OON services in March 2015. For AK, CT and NY where Fair Health 80th percentile has been in place as an official benchmark for OON reimbursements, there is no evidence that the MBS has caused premiums to increase.

Q: Will doctors just raise their rates to the MBS?
- Currently there are hospital and community restraints. Doctors are taking care of the community and need to cover their costs to care for all patients including those with no insurance or coverage by government payers such as Medicaid and Medicare.
- The 80th percentile of charges can be benchmarked to a specific year with added medical cost of living inflation index added each year. This controls upward pressure on the minimum benefit standard.
- Physicians will still have competitive pressures to charge reasonable prices. (see above)

Q: Why would one use charges to determine payment?
- Most physicians already charge reasonable rates for services
- Historically, the 80th percentile of charges is the industry MBS standard. For example, Alaska has been using the 80th percentile as their MBS since 2004
- Charges are reflective of other payments and expenses due to large uninsured populations, difficult to staff locations and other local pressures
- By using 80th of FH, the top 20% of "outliers" are excluded.
- There are many competitive and business pressures preventing most doctors from charging excessive rates. (see above)

Q: Will an MBS lead to a decreased amount of physician contracting? No.
- Both patients and providers deserve protection from insurers who do not have adequate networks. Patients and providers should be protected from this cost-shift by imposing a payment standard on health plans and insurers.
- Physicians will still have incentives to contract: easier billing, decreased coding disputes, increased patient volume due to being in-network.
- Hospitals require physician groups to negotiate in good faith with health plans that are contracted with the facility.

Q: Should insurers pay copays and deductibles directly to the provider for EMTALA mandated care? Yes.
- Emergencies are unforeseen and should be covered. It is between the insurance company and the patient how to divide that cost. The insurance company should pay the provider fully for the care rendered.

- Most "surprise" bills are due to patients responsible for high deductibles and copays. Banning balance billing will not solve that problem. Increasing the transparency of what the insurer covers and does not cover will solve the "surprise" part.
- Insurers game the system by setting high deductibles and co-pays and offering very few in-network emergency physicians. Then, despite being "covered" for emergency care, the patient is left paying most of the bill.
- Having the insurer responsible for co-pays and deductibles increases transparency.
- The inability of physicians to collect patient cost sharing dollars can lead to increased charges to offset the lost revenue.

Q: Why are ED charges higher than a primary care visit?
- Standby expenses for emergency physicians means they must be ready and available for any emergency. In other practice settings the ED is the backstop. One would expect that the failsafe/backstop to have higher costs.
- Uninsured patients typically have no ability to pay for emergency care, leaving emergency physicians without compensation for their services.
- Low reimbursement for upwards of 65% of ED patient visits from sources such as Medicaid, Medicare, Worker's Compensation, and Veteran's Affairs benefits means that emergency physicians are reimbursed at less than the cost of care provided.
- Lack of ability to collect co-pays and deductibles from patients before treatment amounts to emergency physicians collecting on average less than 40% of the patient's cost-sharing responsibility.

Q: Are physician charges the main source of high medical costs? No.
- Physician payments only comprise 7% per health care dollar. Of that 7%, only a tiny fraction of that is OON. Even less is OON emergency care.

Q: Why not use a Medicare database?
- Medicare rates do not correlate with non-Medicare costs/charges by physicians.
- Medicare does not accurately reflect practice costs.
- Medicare has not kept up with inflation. In 2012, the American Medical Association noted there was a 20% gap between what Medicare pays and what it costs physicians to treat patients.[1]
- Medicare rates are unequal across specialties.
- Medicare is based on federal budget constraints, not actual costs to provide care.
- Insufficient payments - like those tied to a low percentage of Medicare rates - could force providers to leave the state or close their practices.
- Inadequate payments reduce access to care and endanger the health care safety net.
- Many rural and smaller community hospitals would be forced to close if they were paid up to 200% of Medicare.

Q: Is this rate setting? No.
- MBS is based on physicians' charges, independently set according to local practice dynamics.
- Insurers can contract to obtain lower rates in return for consideration they provide to providers (eg, expedited claims processing, quicker payment, increased patient referrals….)

Q: Why do physician charges vary by geography/location?
- There is geographic disparity in providing services. This is based upon different practice costs and different populations, particularly with respect to socio economic variation. Practice costs

may vary due to different costs of doing business in an area and availability or lack of availability of tertiary care hospitals.

- To aggregate practices, aggregates of geozips can be used, such as FH geo zips. Alternatively, Medicare metropolitan areas can be used in areas where a single insurer provides insurance to a large percentage of the commercially insured population it is very difficult for physicians to have "fair" negotiations for contracted rates.

Q: Why is there so much disparity between various ED practices?

- By using the 80th percentile of charges, high outliers are excluded.
- ED practices, even in the same area, may have vastly different economics due to different patient and payer mixes.

Q: Why do physician payments matter? They are already overpaid.

- Physicians have significant practice costs:
  - Maintaining standby readiness, EDs must be staffed 24x7 to be prepared for any emergency even if typical volume is low.
  - Professional liability costs are high in EM due to the nature of unanticipated health crises and EMTALA.
  - Ongoing professional education and other responsibilities.
  - Attracting the best physicians to their practice.
  - Administrative work involved in optimizing ED operations and establishing protocols and coordination with the community (public health, EMS, industry….)
- Without adequate payment, there will be a lack of on call specialists, longer waits, and lower quality of care, jeopardizing the safety net.
- Physicians invest an incredible amount of time and money considering the opportunity cost, time, and associated debt from medical training required to be a physician.

Q: Why are surprise bills so high?

- What are frequently referred to as “surprise medical bills” are actually an exercise in cost shifting from insurers to patients. Insurance companies are increasingly narrowing their physician networks by offering physicians take-it-or-leave-it reimbursement deals that are not financially sustainable. As a result, more and more physicians are being forced out of network (OON) and issues regarding access to care are growing.
- Insurers are increasingly underpaying OON charges creating a “surprise insurance gap” – the difference between what it costs the physician to provide the service and what the insurer will pay for it. Insurers compete on premiums and deceptively offer unreasonably low provider rates, high deductibles and high copays.
- Many insurers do not consider OON charges when determining the out-of-pocket maximum that patients are responsible for – this only imposes additional, and oftentimes significant, financial burdens on patients. Deductibles, for example, have increased significantly in recent years, with average plans requiring patient spending of $2,000 - $6,000 before most coverage begins.
- Insurers can decide which individuals to cover, as well as which physicians to bring into their network. As more insurance companies consolidate and narrow their network coverage of medical providers, they increase the likelihood patients may find themselves in out-of-network situations.

Q: Why is a payment standard required? Why not use arbitration/mediation without a payment standard?

- The goal is to get patients out of the middle of disputes and ensure access to care.
- Most physicians are smaller businesses that cannot absorb the costs of waiting for payment after lengthy arbitration procedures.

- The cost of arbitration outweighs the low amount paid for most claims. Thus, a MBS is necessary.
    - Because most emergency claims are for relatively small amounts, the cost of arbitration will be a high percentage of the disputed fee, thus arbitration expenses will dissuade seeking arbitration.

Q: Why do emergency physicians and EDs fail to tell patient what the bill will be?

- EMTALA requires providing emergency care prior to discussing payment. This protects patients from feeling pressured to make financial decisions when facing a medical emergency.
- Insurers have very complex networks and copay/deductible arrangements. There is no way for EPs or EDs to know how much of a service, if any, the insurance company will reimburse.
- MBS at the 80th percentile of an independent database legislation would establish that the insurer pays for emergency care. This will create the first incentive for insurers to be transparent about pricing and coverage.

Q: Why use the FAIR Health (FH) Charges Database?

- The NORC report concluded that FH was the best database available for this purpose when compared with other alternatives such as HCCI, Truven Health Analytics, and All Payer Claims Database Council at the university of Virginia (see "Establishing an MBS for OON Services: Charge Databases" section above).
- FH makes its data available to states at no charge.

Possible Alternative MBS Standards

While the preferred MBS should be based on the 80th percentile of an independent non-profit charge database, the following discussion provides alternatives to the FH charges database. States that are contemplating balance billing bans must develop a payment standard to prevent insurers from unilaterally deciding payment amounts for emergency provider services. Some states have adopted FH as a payment standard, but other states have refused to accept FH as a payment standard. What other payment standards can be considered when FH is not an option?

Average of Allowable Benefit and Charges

Payers use an allowable benefit to determine OON payments for emergency providers. Emergency provider charges are typically higher than the allowable benefit. As a result, emergency providers rarely receive charges in full for services rendered. As a compromise, the average between the provider's charges and the allowable benefit could represent a payment standard that represents a compromise between providers and health plans. The payment standard can be determined for a base year and then adjusted for inflation going forward.

Gould Criteria

The Gould criteria was based on a trial, Gould v. Workers' Comp. Appeals Bd. (1992) 4 Cal.App.4th 1059, that involved defining the "reasonable and customary value," for physician services. There are six criteria that are used:

1. The provider's training, qualifications, and length of time in practice
2. The nature of the services provided
3. The fees usually charged by the provider

4. Prevailing provider rates charged in the general geographic area in which the services were rendered
5. Other aspects of the economics of the medical provider's practice that are relevant
6. Any unusual circumstances in the case

The Gould criteria use provider charges as one of the factors in determining the fair value of services, but it does not specify which database is used. The Gould criteria should be reserved for the dispute resolution process since, the Gould criteria is vague and does not establish a specific dollar amount that is the reasonable and customary value for services. As a result, disputes between providers and payers over usual and customary payments often occur.

Payment of Charges with Arbitration

Arbitration can be used as a means of settling disputes, but it is a time consuming and expensive process. However, if payers are required to pay providers charges, before arbitration, this could potentially be a solution. If provider's charges are reasonable, then a payer will not pursue arbitration. Baseball-style arbitration can be used to determine the payment where both sides present their best offer and the arbitrator must choose the most reasonable offer. The loser may be required to pay the cost of arbitration if baseball style arbitration is used.

Mediation

Some states have established a mediation process if the amount of a balance bill exceeds a certain amount. For example, Texas created a mediation process for balance billing disputes that exceeded $500. Mediation is conducted between the patient, insurer and emergency provider. To reduce the frequency of mediation the threshold for mediation should be at least $1000 per claim. If mediation is required, the 80th percentile of an independent non-profit charge database, such as FH, should be incorporated as the payment standard.

State All Payer and Claims Database (APCDs)

Several states have APCDs that can potentially be used if the FH database is not an option. The state databases can be compared with FH to determine if the state database is comparable to the FH charges database. The FH charge database does not include ERISA claims which may account for the discrepancy with an APCD. There are over a dozen states that have an APCD or are currently implementing one. Only charge APCD databases should be considered.

Percentage of Contracted Rates

Emergency providers typically provide a discount for contracted rates. The amount of the discount varies depending upon the insurer's market power, provider requirements to contract at in-network facilities or benefits to the provider for contracting. Contracting with insurers may also result in direct and faster payments to the provider. Typical discounts are between 15-50% of charges. To encourage insurers to contract, the non-contracted payments must be above contracted rates. This can be achieved by setting non-contracted payments at a rate that is above previously contracted rates. In Maryland, PPOs are required to pay 140% of the contracted rate of the previous year. For HMOs, the payment standard is 125% of the contracted rate from the previous year. For Maryland to capture the discount for most contracted rates, an out-of-network payment standard of at least 150% of the contracted rates is desirable. In other states, the percentage of contracted rates may need to be adjusted to establish an adequate minimum benefit standard. The rates can be adjusted for inflation thereafter. The downside is if an emergency provider group is new to a state, there is no previous contracted rate that can be used to

determine non-contracted rates. In these situations, a minimum of 150% of the payer's average contracted rate could be used as a payment standard. However, the average contracted rate is subject to manipulation by the insurer and lacks transparency.

Percentage of Medicare

A percentage of Medicare is the least attractive option. However, if forced to base payment standards on a percentage of Medicare, there must be an adjustment for the various specialties. According to a study by the Journal of the American Medical Association (JAMA), provider charges as a percentage of Medicare ranged from as low as 200% to over 500% of the Medicare allowable depending upon the specialty. The median charge for emergency physicians was 400% of Medicare allowable. The high cost of providing emergency care as previously described is reflected in the charges that are necessary to maintain a practice.

Created by members of the ACEP-EDPMA Joint Task Force, June 2018
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A Fair Minimum Benefit Standard to End the "Surprise Insurance Gap" in Emergency Care

Emergency services are the very foundation of the American health care system. The ability to deliver exceptional, lifesaving care 24/7 is expensive. Inadequate payments from insurers are undermining the financial stability of the emergency care system. Without a solution, insurers are depleting our ability to care for America's sick and injured, and to respond to emergencies.

Insurers are Threatening Emergency Care

1. Fair coverage of emergency services is under attack by insurers. By denying coverage to patients and limiting payments to doctors, insurers are creating "insurance gaps" that leave patients exposed to unexpected bills.
2. Insurers are aggressively advocating for extremely low "minimum benefit standards" (MBS) – the minimum amount paid to out-of-network emergency physicians for their services.
3. While patients are paying for insurance, insurance companies aren't compensating doctors fairly. Instead, they are making small payments through these artificially low MBS. This leaves patients stuck in the middle and exposed to additional costs.

Emergency physicians are working to reduce patient financial liability while preserving access to emergency care. The American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) agree on a solution: setting the MBS at the 80th percentile of FAIR Health's usual and customary charge database.

Insurers Should Pay for the Cost of Emergency Care

1. Insurers want an MBS for out-of-network emergency care linked to "**allowable**" payment databases – databases designed by and for insurers without regard to the actual cost of providing care. These databases are not transparent and can be manipulated by insurers.
2. Physicians have demonstrated that "**charge**" databases reflect the actual costs of care to maintain a functional emergency medical system, are transparent, and reflect local markets.
3. FAIR Health is currently the only independent, not-for-profit organization free from insurer bias that has a robust charge database for use in determining fair payment standards.
4. Benchmarking an MBS standard to the 80th percentile of a transparent charge database eliminates the highest, outlier charges while reflecting local markets. Leveraging market forces also encourages insurers to negotiate in good faith with emergency physicians.

Instead of shifting costs from insurers to patients, a fair MBS eliminates unexpected balance bills, creates a fair reimbursement system for out-of-network emergency care, and preserves the emergency care system.

Patients Will Benefit

1. Take patients out of the middle and end surprise bills for unexpected emergency care by establishing a fair payment standard based on an MBS tied to the 80th percentile of the FAIR Health charge database.
2. Create an incentive for insurance price and coverage transparency by tying MBS payments to data provided through an independent, not-for-profit organization that serves the better interest of patients – not insurers or providers.
3. End "surprise bills" for patients and ensure access to excellent emergency care by providing reimbursement that reflects the actual costs to provide care.