CALIFORNIA ACEP
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Peter Lee
Executive Director
California Health Benefit Exchange
2535 Capitol Oaks Drive, Suite 120
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August 6, 2012

Dear Mr. Lee,

The California Chapter of the American College of Emergency Physicians (California ACEP) appreciates the opportunity to submit comments regarding the "Standardization of Minimum Out-of-Network Benefits" as outlined on page 83 of the document entitled "Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability: Discussion Draft – Options and Recommendations July 16th 2012". California ACEP welcomes the opportunity to provide recommendations to the Health Benefit Exchange to meet the mission of the exchange and to provide increased transparency to consumers, providers and health plans.

Patients often seek out-of-network emergency services since emergency conditions often require patients to obtain care at the nearest emergency care facility. Not infrequently, the emergency provider may be out-of-network if the provider is not contracted with the patient's health plan. In those situations, the provider will bill the health plan for services. The health plan will determine the health plan's usual and customary rate that will be paid to the emergency provider. The amount that the provider receives from the health plan can vary tremendously. In some cases the health plan can delegate financial responsibility to a risk bearing organization. The risk bearing organization may determine usual and customary rates for out-of-network services that are vastly different than the rates that are paid by the health plan. If the health plan's product line is not regulated under the Knox-Keene Act, providers are permitted to balance bill the patient for the difference between the provider's charges and what is paid by the insurer. Although providers do not like to balance bill patients, balance billing allows providers to be reimbursed adequately when the health plan reimburses providers at an unreasonable amount. Unfortunately, patients do not know how much the out of pocket expense will be incurred until the provider can determine how much the health plan pays. Clearly a payment standard is required to eliminate the uncertainty of payment amounts by health plans and out-of-pocket expenses for patients.

California ACEP agrees that the consumer needs to be protected from unreasonably high charges. The intent of the health exchange is to protect consumers and limit financial risks. The Health Care Exchange staff has recommended standardizing minimum out-of-network benefits including a maximum fee that can be charged by a provider for out-of-network claims. However, providers also need to be protected from health plans that reimburse at unreasonably low rates. Under the Emergency Medical Treatment and Active

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Labor Act and under California Health and Safety Code Section 1317, emergency providers must provide emergency care regardless of the patient's insurance status. Emergency care providers generally do not have any control over which type of patients, insured or otherwise, seek emergency care at a specific facility. Nonetheless, emergency care providers are obligated to provide care to all patients, even if the Knox-Keene regulated health plan or risk bearing organization does not submit adequate payment for in-network or out-of-network services rendered. Emergency physicians who provide services in good faith should receive adequate reimbursement for the care provided.

The payment standard for out-of-network services should provide transparency to consumers, providers and regulators. Patients should be able to determine the out-of-pocket expense for out-of-network care, and know that their benefits for these services are reasonable and appropriate. Providers need to know the amount that will be paid for out-of-network services and health plans should know how much to pay for non-contracted services, based on clearly defined payment and benefit standards. Payment standards should also reflect the expense of providing services in a geographic area to reflect local market conditions. For complete transparency, the payment standards need to be based on published and publically available databases. The Health Benefit Exchange Staff has suggested using a percentage of Medicare to determine a cap for out-of-network services.

California ACEP is opposed to capping what an emergency physician can charge for out-of-network care. Due to the unique nature of emergency care many times patients are not in a situation to choose which emergency department they go to. As a result neither the patient nor the emergency physician chooses in advance to be out of network. Currently, emergency physicians are at a significant disadvantage when negotiating contracts and rates with insurers due to federal and state law requiring emergency physicians to see all patients coming into the emergency department. This requirement gives the health plans and health insurers a tremendous advantage when negotiating a contract because they know if the emergency physician does not accept the contract rate the emergency physician will still see their enrollees. If the cap level were too low, it would result in precious dollars being diverted from the emergency care safety net. Taking money out of the emergency medical safety net will lead to fewer emergency physicians staffing emergency departments. Reduced staffing will lengthen waiting times even beyond their current conditions, further threatening patient outcomes.

Additionally, California ACEP is opposed to using a percentage of the Medicare fee schedule since the formula used to determine Medicare reimbursement rates for providers is flawed. The sustainable growth rate formula used to determine provider reimbursement rates is tied to the gross domestic product and other budgetary constraints. Without Congressional intervention, Medicare reimbursement to providers is scheduled to be cut by 27% next year. Because of the flawed formula, Medicare reimbursement rates have not kept pace with medical inflation. Medicare rates are unpredictable and do not truly reflect the cost of providing medical care or the reasonable commercial market value of

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these services. In addition, the Medicare fee schedule is also not available to the public in a consumer friendly format.

Fair Health is a national, independent not-for-profit corporation that provides transparency to healthcare costs by providing unbiased data products to consumers, providers, healthcare community, employers, government agencies and researchers. The database was culled from millions of actual medical bills. The Fair Health database is available through a free website (http://www.fairhealth.org.) Consumers can use the website to research the approximate costs for of out-of-network medical services in a geographic area. Fair Health was created because consumers and providers did not have access to the database that was owned and controlled by insurance companies to determine payments for out-of-network services. After investigating these complaints, Andrew Cuomo, the former New York attorney general, launched an investigation into the insurance company's ownership of the database. The attorney general determined that there was a conflict of interest for insurance companies to control the database used to determine reimbursement rates, and as a result, millions of enrollees were burdened with hundreds of millions of dollars in unnecessary out-of-pocket costs. As a result, the Fair Health database was established in 2009 and is maintained by a team of independent experts at no cost to the public. The Fair Health database has been endorsed by the American College or Emergency Physicians as a tool for determining out-of-network reimbursement rates and providing transparency.

California ACEP recommends the following for emergency care services obligated under EMTALA:

The California Health Benefit Exchange should require health plans to reimburse out-of-network emergency services at: the lesser of the provider's usual and customary charge or the 80th percentile of the usual and customary charges based on the most recently published Fair Health database for providers located in the same three-digit geo-zip as the provider, less any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. The payment standard would also apply to risk bearing organization that has been delegated financial responsibility by the health plan.

The Fair Health database will provide patients, providers and health plans total transparency. Patients will be protected from excessive charges (those that exceed the 80th percentile of usual and customary charges) and providers will be protected from unfair payments. The patients would only be responsible for the same copayment or coinsurance whether the provider is in-network or out-of-network. This approach will also help to preserve access to emergency care services by qualified emergency physicians, and by other specialists who are on-call to the emergency department, in the face of rapidly eroding on-call specialty panels. These fair payment / benefit standards will also ensure that EDs in California remain open to treat everyone who requires emergency care, regardless of insurance status or ability to pay.

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California ACEP is appreciative of the opportunity to submit comments on the California Health Benefit Exchange to allow the best emergency care possible in California.

Sincerely,

Andrew Fenton, M.D., FACEP

Andrew Fenton, MD, FACEP
President

cc: The Honorable Dave Jones, Insurance Commissioner
The Honorable Ed Hernandez, Chair Senate Health Committee
The Honorable William Monning, Chair Assembly Health Committee