

A Resource for Emergency Physicians on Balance Billing, Out-of-Network Fees, and Surprise Bills

from

The Independent Practice Support Committee of the American Academy of Emergency Medicine

What is a “surprise bill” in the context of emergency medicine?

When a patient is cared for in an emergency department (ED), he or his insurer is billed for a facility fee by the hospital and a professional fee by the emergency physician – or the entity employing the emergency physician or other provider who rendered care. Sometimes the patient finds he is liable for more out-of-pocket costs than he expected. This has become known as a “surprise bill.” In the case of an insured patient, it is more accurately a “balance bill” because it is a bill for the balance of the emergency physician's professional fee that was not paid by the insurer.

Why is this such a hot topic now?

For three big reasons. First, insurers are deliberately narrowing their provider networks in order to shift more costs onto their customers (patients) and protect or increase their profit margins, knowing patients have to pay a greater percentage of their medical bills when they see an out-of-network (OON) provider. Second, while health insurance premiums were steadily climbing even before passage of the Affordable Care Act, better known as “Obamacare,” they have skyrocketed under Obamacare. This has driven many consumers to high-deductible policies in an attempt to lower their premiums. These policies often require that patients pay thousands of dollars per year out-of-pocket before insurers begin covering medical bills. Patients are often shocked to find that their insurance doesn't cover the cost of **emergency** care from the very first dollar. Third, patients seem to have forgotten – or never knew – that most physicians, including hospital-based specialists like emergency physicians, are small businessmen and women who own their own practice. Patients often falsely assume that if the hospital is in-network with their insurer, all the physicians there will be too.

When patients complain to their insurers about a surprise bill following emergency medical care, insurers don't shoulder the blame for failing to educate their clients; or for failing to make current and accurate information available to their clients on which physician groups are in- or out-of-network; or for deliberately offering unreasonable contract terms to emergency physician groups, thus making sure those groups stay out-of-network; or for failing to cover the cost of emergency care from the first dollar. No, what they say is: “It's those rich, greedy doctors. They refuse to participate in our network. You should call your legislators!”

The insurance industry has launched a nationwide effort to limit or prohibit balance billing and cap OON fees, pretending their crusade is an attempt to protect patients rather than increase their profit margins. If you haven't already, you must start educating your state and federal legislators on the facts of this issue before our country's medical safety net is shredded and our neediest and most vulnerable patients have nowhere to turn. The Independent Practice Support Committee hopes you find this information useful in your communications with legislators, regulators, and patients.

Talking Points

- When a patient is surprised at his out-of-pocket costs following a visit to the emergency department, that is increasingly due to the fact that his deductible for the year has not been met. That is strictly an issue between the patient and his insurer, and has nothing to do with the hospital or emergency physician group being in- or out-of-network. Emergency physicians have no way of knowing what a patient's deductible is or whether it has been met for the year. We usually don't even know if the patient has insurance at all. In fact, we couldn't possibly care less. **We take care of the patients who need us and worry about payment later.**
- Emergency physician groups want very much to be in-network with insurers. Being in-network means we get paid faster, with less hassle, and with lower overhead costs. And since we carry such a huge charity burden, averaging about \$140,000/year for each emergency physician in the United States just for EMTALA-mandated care,¹ we want to do anything we can to lower overhead costs. Furthermore, being in-network means fewer patient complaints and a much happier hospital administrator, making our contract with the hospital – and thus our jobs – more secure.
- When we stay out-of-network, it is usually because insurers refuse to negotiate in good faith. Insurers know we are required by federal law (EMTALA, the Emergency Medical Treatment and Active Labor Act of 1986) to take care of every patient who comes to the emergency department – regardless of insurance status or network, regardless of what an insurer will pay, and regardless of the patient's ability or willingness to pay for care. Insurers thus have little incentive to offer emergency physicians fair contract terms – they know we will take care of their clients, **our patients**, no matter what. The only negotiating leverage emergency physicians have is the possibility of staying out-of-network and billing the insurer at a significantly higher rate than the discounted in-network rate, and sometimes even balance billing the patient. If OON fees are capped, and to a lesser degree if balance billing is severely restricted, insurers will have no reason at all to entice emergency physicians to participate in their networks. **Insurers will be free to decide entirely on their own what they are willing to pay for emergency medical care**, because they will no longer care if emergency physicians stay OON. This will free insurers to pay less and less for in-network emergency care too. This will eventually drive independent emergency physician groups out of business, and lead to the closure of emergency departments and even entire hospitals.
- **EMTALA makes it illegal to warn an emergency department patient that either the hospital or physician group is OON**, until after the patient has been examined and any emergency medical condition has been resolved. Federal regulators consider such warnings an attempt to coerce the patient into leaving without receiving medical care. A single EMTALA violation opens the hospital up to a lawsuit, a \$50,000 fine, and even disbarment from participating in Medicare and Medicaid – a death sentence for a hospital. It also exposes the individual emergency physician to a possible \$50,000 fine that is not covered by malpractice insurance.
- Insurers and emergency physicians already negotiate on a playing field that is far from level, both for the reasons explained above and because in many places insurance companies constitute an oligopoly. In fact, in many areas a single insurer has an outright monopoly. Capping OON fees would take an already uneven field and stand it on end in favor of some of the richest and most powerful corporations in the country. **Judging from the annual compensation of their CEOs, health insurers are doing just fine without the extra help.**
- Independent physicians and physician groups, however, cannot band together to bargain collectively with insurers. Regulators consider that collusion in restraint of trade, and a violation of antitrust laws. Thus we are deprived of the normal defense against insurers' monopolistic power.
- Most, if not all, emergency physicians would be happy to forego balance billing entirely if insurers would cover the cost of emergency care from the first dollar and pay us fairly – meaning at least at the 80th

- percentile of the “usual & customary” rate according to the FAIR Health database – but insurers refuse to do that because they don't really care about protecting patients, they care about their profit margins.
- If the insurance industry is truly serious about reducing out-of-pocket costs for its customers, at the very least it should support changing the existing laws that make it difficult or impossible for emergency physicians to waive out-of-pocket charges for patients without being charged with insurance fraud.
 - Medicaid doesn't come close to covering the cost of keeping an emergency department open and running 24 hours a day, seven days a week, and most EDs barely break even on Medicare. **The money that funds our charity mission and the nation's medical safety net comes from the small minority of emergency department patients with commercial insurance.** If that funding is drastically cut, as it will be if OON fees are capped, either federal and state governments will have to make up the shortfall or the safety net will unravel.
 - At a fundamental level, this isn't really an OON fee or balance billing problem at all, but an inadequate insurance issue. The real problem is that too many health insurance policies have gaps in their coverage of medical emergencies, when emergency care should be covered more completely than any other kind of healthcare.

Important Background Information

Myles Riner's excellent blog, *The Fickle Finger*, has posted at least three important articles on this topic. All are quite short and easy to read.

1) <http://www.ficklefinger.net/blog/2016/09/23/usual-customary-charges-reasonable/>

It is critical that you read and understand “Are Usual and Customary Charges Reasonable?” and then make sure your state legislators understand the facts it lays out. It provides some historical background on this issue, and most importantly explains how and why the FAIR Health database was created. Previously the Ingenix database was used to determine usual and customary (U&C) charges. Ingenix was owned by United Healthcare, a major insurer. The state attorney general of New York caught insurers manipulating the data on charges and sued several companies. Part of the penalty levied against the cheating insurers was that they had to fund the creation of an independent database on medical fees, FAIR Health (<http://www.fairhealth.org/About-FH>), that they couldn't falsify so easily. As the FAIR Health website puts it:

FAIR Health, Inc. was established in October 2009 as part of the settlement of an investigation by New York State into certain health insurance industry reimbursement practices which had been based on data compiled and controlled by a major insurer. FAIR Health was formed to create a conflict-free, robust, trusted and transparent source of data to support the adjudication of healthcare claims and to promote sound decision-making by all participants in the healthcare industry.

Strangely enough, now that insurers don't control the data on medical charges they refuse to use the database to determine U&C fees. Dr. Riner also notes in this article that **premiums have been going up in lockstep with insurance industry profits, rather than to cover insurance company losses** (<http://pnhp.org/blog/2010/06/22/are-high-premiums-due-to-medical-costs-or-insurer-profits/>).

2) <http://www.ficklefinger.net/blog/2016/10/14/brookings-institute-misfires-surprise-balance-billing/>

This article rebuts several arguments insurers use to convince legislators to cap OON fees, and discusses insurers' monopolistic power and the practice of “coercive contracting.” It also discusses the dangers of forcing emergency physicians into a mandatory mediation or dispute resolution process before they are paid for professional services they have already rendered. Huge corporations may have the resources to take hundreds or thousands of small claims through such a process each year

– and nearly all balance bills are small claims – but smaller, independent, physician-owned emergency medicine groups cannot afford to do that and will be driven out of business.

- 3) <http://www.ficklefinger.net/blog/2017/03/28/mandating-coverage-emergency-care/> This article discusses the unfunded federal mandate, EMTALA, and reviews the economics of emergency medicine. It points out how critical reimbursement from private insurers is to America's medical safety net and predicts what will happen if that funding is cut.

Other Resources

The National Association of Insurance Commissioners (NAIC) has written model legislation that it believes would remedy the balance billing problem (<http://www.naic.org/store/free/MDL-74.pdf>). It is difficult and painful to read – let's just say it looks like the folks at NAIC work for the insurance industry. The model legislation does protect patients, banning balance bills for emergency care that haven't been through a mediation process, but it does nothing to protect EDs and emergency physicians from predatory insurance companies. If passed into law without significant changes, this model bill would drive many emergency physician groups into insolvency and lead to the closure of some hospitals, destroying the medical safety net.

A summary of what states have done so far on balance billing can be found here: <http://nashp.org/wp-content/uploads/2016/04/Surprise-Balance-Billing.pdf>. And although it isn't specific to emergency medicine, this paper from the National Academy for State Health Policy also includes a good summary of the whole issue. Be aware that this is a rapidly changing area of activity, and this paper is over one year old.

If your state legislators want to know if any state has acted to protect patients from unexpected OON bills for emergency care and done it well, point to Connecticut: <https://www.cga.ct.gov/2016/BA/2016SB-00433-R01-BA.htm>. Though based partly on the NAIC model, the Connecticut legislation prohibits a health insurer from requiring prior authorization for emergency services and from charging an insured patient more (a higher coinsurance, deductible, or other out-of-pocket amount) for emergency care from an out-of-network provider than from an in-network provider. In the event an OON provider renders emergency services to an insured, the health insurer must reimburse the health care provider at the **greater** of 1) the in-network rate; 2) the usual, customary, and reasonable rate; or 3) the Medicare rate. This legislation defines “usual, customary and reasonable rate” as the **80th percentile of all charges for the service provided in the same geographic region by a same or similar specialty, as determined by reference to a database designated by the insurance commissioner** (and FAIR Health was chosen).

An organization called Physicians for Fair Coverage (<http://thepfc.org/>) was created specifically because of the OON fee/balance billing issue, and describes itself as:

Physicians for Fair Coverage (PFC) is a growing multi-specialty alliance of physician groups advocating to improve patient protections and **End The Surprise Insurance Gap**, while promoting transparency and increasing access to care.

We are currently comprised of tens of thousands of emergency physicians, anesthesiologists, and radiologists nationwide who annually serve tens of millions of patients.

At its website it provides several extremely useful resources. These include information on FAIR Health (<http://thepfc.org/wp-content/uploads/2016/11/FAIR-Health-Facts-1.13.17.pdf>); a very simple, one-page summary of how this problem can be solved while protecting both patients and the medical safety net (<http://thepfc.org/wp->

content/uploads/2016/12/PFC_NJ-Bill-Statement_12.5.16-FINAL-.pdf); and even a summary of principles for model legislation to end surprise balance billing without driving emergency physician groups and even hospitals into insolvency (<http://thepfc.org/wp-content/uploads/2016/11/SUMMARY-PFC-DRAFT-MODEL-LEGISLATION-4.pdf>).

A 1998 letter from the Centers for Medicare & Medicaid Services is very important.² It includes this:

We interpret coverage to mean that an MCO must pay for the cost of emergency services obtained by Medicaid enrollees. In addition to establishing an obligation to cover emergency services, the law further stipulates that emergency services must be covered without regard to prior authorization or the emergency care provider's contractual relationship with the organization. These provisions collectively enable a Medicaid enrollee to immediately obtain emergency services at the nearest provider when and where the need arises. The responsibility of MCOs regarding the coverage of emergency services is explained in more detail in the attachment.

Emergency services are defined broadly by the BBA to mean covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard described below.

An explanation of the prudent layperson standard is also included. A medical emergency is defined as:

...a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part. While this standard encompasses clinical emergencies, it also clearly requires MCOs to base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and to cover examinations where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

In other words, an emergency is defined by presenting symptoms, not final diagnosis. Insurers are not allowed to deny coverage because the severe chest pain and shortness of breath turn out to be a panic attack instead of a heart attack or pulmonary embolism.

Final Points

The American Academy of Emergency Medicine will defend you and your patients on this issue at the national level, but like most healthcare controversies, the OON fee/balance billing problem will be solved largely at the state level. **If your state legislature isn't already wrestling with this, it soon will be.** Several states already have, and unlike Connecticut, most have favored insurers. Remember: we want a solution that protects patients from unexpected or huge out-of-pocket bills for emergency care, but any legitimate solution must shift the burden to where it belongs – with insurers.

- Insurers should offer emergency physicians fair contracts that ensure adequate networks for emergency care, and they will have no reason to do so if their liability for OON fees is capped.
- Insurers should pay for OON emergency care at the usual and customary rate, meaning no less than the 80th percentile of usual and customary as defined by a fair, accurate, independent database such as FAIR Health.
- Patients themselves shouldn't have to pay more for out-of-network emergency care than for in-network emergency care.

- Insurers should keep up to date data on which hospital-based physician groups are out-of-network, especially at in-network hospitals, and make this information easily available to their clients.
- Attempting to solve the balance billing problem with a mediation or dispute resolution process is too cumbersome and expensive for many emergency physician groups, which are small, locally-owned businesses.
- The prudent layperson standard should continue to define “emergency.”
- When it comes to emergencies, insurers should cover costs from the very first dollar. **That would really protect patients.**
- Emergency physician groups and EDs should be allowed to waive a patient's out-of-pocket charges without running the risk of being accused of insurance fraud, and if insurers pay adequately for emergency care emergency physicians will be able to waive those charges entirely. Again, **that would really protect patients.**

Andy Walker, MD FAAEM

References and Attachments

1. Kane CK. Physician marketplace report – the impact of EMTALA on physician practices. The Center for Health Policy Research, American Medical Association; Feb 2003.
2. <http://www.aaem.org/em-resources/regulatory-issues/emtala/hcfa-letters>