December 1, 2016

VIA EMAIL
Rep. Ron Travis
ben.sanders@fbitn.com and brittney.jones@capitol.tn.gov

Re: Balance Billing Legislation

Dear Members of the Tennessee Work Group on Balance Billing:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. **Together, EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year.** We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

We offer you comments on how to make sure patients are informed about their financial responsibilities for healthcare ahead of time and avoid surprises. Because we represent emergency physicians, we will focus our comments on potential surprises when obtaining emergency services.

The biggest surprise is when the patient receives a large bill and **they learn of the huge surprise gap in their insurance.** Emergency care is an "essential benefit" which is "covered" whether it is provided by in-network or out-of-network doctors. So, patients often are shocked to receive larger-than-expected bills for emergency care. They mistakenly assume the bill is a reflection of the doctor's charges over and above fair reimbursement from the insurance company. Yet, in most instances, the bill is simply a reflection of the patient's out-of-pocket costs related to their deductible, co-insurance or copayment responsibilities, which can be quite high. And the emergency physician is neither aware of these surprise insurance gaps nor in control of limiting them.

Emergency bills can contain other unwelcome surprises like expensive bills for transporting the patient to the hospital in an ambulance or helicopter, the "facility fee" which helps cover the cost of having the hospital's many resources on hand, or a specialist's fee when specialists were consulted. Again, the emergency physician cannot control these surprises.

The emergency physician doesn't even have control over the small portion of the bill that reflects the emergency physician's charges because the insurance company unilaterally decides – in a black box – how much will be paid by the insurance company and how much will be considered the patient's responsibility.

Beyond these surprises, the patient is often left confused when it comes time to pay the bill. The patient is faced with numerous versions of the bill coming from a variety of sources: the insurance company, doctors, hospitals, and transporters. And patients must figure out which bills overlap and which bills reflect fees that have already been covered – or will be covered – by insurance.

We believe the solution is transparency and taking the patient out of the middle. The insurance company is the party with access to all of the relevant information and the one with a contractual relationship with the patient. So, the insurance company should be tasked with educating its beneficiaries on what the deductible, coinsurance, and copayments are and when and how they are applied. The insurance company should be tasked with explaining potential facility, transportation, and specialty fees. They should also answer questions on which provider is in-network and the likely range of costs for certain procedures. And, if the insurance company does not adequately fulfill its responsibilities to inform patients of their coverage – and coverage gaps - the patient should be able to request financial compensation from the insurance company.

We also believe the patient should be taken out of the middle when it comes to the confusing mass of bills that arrive after the emergency. We recommend that the insurance company be required to pay the providers in full. Then, the insurance company should collect the patient's contribution directly from the patient, including any coinsurance, copayments, and deductibles. This way, confusion is virtually eliminated, the patient has only one entity to deal with, and patients will no longer be confused and think a bill reflects overcharges by physicians when, in fact, it represents surprise gaps in insurance.

We recommend that you also encourage transparency between the insurance company and the emergency physician. We urge you to fix the problem that reimbursement rates are developed in secret and unilaterally by insurers. You should clearly define "usual, customary, and reasonable" (UCR) by tying it to a transparent, independent (unbiased), charge database. We recommend that you clearly require insurers to pay UCR – at minimum – and define UCR as the 80th percentile of FAIR Health. (By referencing the 80th percentile, any outlier bills will have been removed from the data set.) FAIR Health was created after conflicts of interest were discovered in the methods that health insurers were using to underpay providers for out-of-network services. As part of the settlement agreements with health insurance companies, the FAIR Health database was established to bring fairness and transparency to the out-of-network reimbursement system.

Please note that, starting this year (July 2016), the Connecticut legislation which was based on this 80th percentile standard became effective. And, if providers are paid fairly by insurance companies under this standard, patients will be responsible for less.

We would also like to take a minute to touch on the surprise billing legislation that was introduced last year, HB2005, which would have limited out-of-network reimbursement to in-network rates. Such provisions would encourage insurers to game the system by setting high deductibles and offering unfairly low in-network reimbursement rates for emergency care. Then, few emergency physicians would join the network. And, despite being "covered" for emergency care, the patient would be forced to go out-of-network, pay a high deductible, and cover most of the bill while the insurer avoids paying its fair share.

Also note that physicians accept in-network rates - which are below market value - because they hope that they will drive patients – and ultimately business - to their practice, which serves as the conduit for participating as an in-network physician. However, since emergency physicians, are bound by EMTALA obligations to deliver care, insurers are not driven by market-based incentives to contract with emergency physicians in the same manner they would be with a community-based provider.

Thank you for considering our comments. And, if you would like us to provide you with any of the regulations or studies referenced in this letter, please do not hesitate to contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org.

Sincerely,

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