



November 3, 2016

Mr. Tom Donovan, Deputy Director
Idaho Department of Insurance
700 West State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043

Ms. Kathy McGill, Health Insurance Specialist,
Idaho Department of Insurance
700 West State Street, 3rd Floor
P.O. Box 83720
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RE: Draft of Potential Legislation, An Act Relating to Network Adequacy

Dear Mr. Donovan and Ms. McGill,

As organizations representing physicians providing emergency health care services to the people of Idaho and across the United States, the American College of Emergency Physicians (ACEP), the Idaho Chapter of ACEP, and the Emergency Department Practice Management Association (EDPMA) appreciate the opportunity to comment on the above referenced draft legislation being prepared by the Department. We appreciate the Department's goal of making sure that Idaho patients purchasing insurance coverage have timely access to medical care. Sharing that goal, we nonetheless have some concerns with some provisions in the draft.

As you are undoubtedly aware, in emergency departments we care for patients under a federal mandate known as EMTALA, the Emergency Medicine Treatment and Labor Act (42 U.S.C. 1395dd). Under that law, a person who comes to the emergency department with a prudent layperson's belief that he/she is experiencing a medical emergency is entitled to a diagnostic examination and stabilizing treatment, regardless of the person's ability to pay or insurance status. We do not complain about this duty; rather, we embrace it, as it recognizes the essential role that emergency medicine plays in our health care system.

We note favorably that your draft includes definitions of "Emergency Medical Condition" and "Emergency Services" consistent with these federal standards.



Nonetheless, we would express concerns with regard to proposed section 41-6207, which addresses “Requirements for Carriers and Non-Participating Providers.” Under that section, a non-participating provider would be reimbursed by the carrier the lesser of the provider’s charges or the carrier’s contracted payment rate.

There are numerous problems with such a provision. A health care provider that contracts with an insurance carrier agrees to accept a discounted rate in exchange for consideration from the carrier, which usually takes the form of steerage of patients to the provider via directories and other means. However, in this proposal, the state is allowing the carrier to utilize a contracted rate in spite of the fact that it is offering no consideration in return. Beyond the question as to whether this is just, one can add that given such a state of affairs there would be little incentive for carriers to contract with providers at all, and this is particularly true with regard to emergency physicians, who are obligated to provide care to patients without regard to their eventual payment. Finally, we would note that contractual amounts are not transparent to nonparticipating providers; thus, the medical provider would have no way of readily knowing if the payment amount is accurate.

While we recognize that the draft attempts to reduce the problem by providing access to a mediation program, the reality is that the vast majority of remaining balances from emergency physician bills are relatively small, meaning that individual bills would hardly be worth the staff time and expense of engaging a mediation process.

In addition, we would note that the proposed solution would be unlikely to address the needs of patients. It is no coincidence that questions regarding balance billing are arising at a time when patients with insurance are finding themselves surprised by their increasing financial obligations resulting from higher deductibles and copays. Thus, the “balance bill” problem often turns out to be a surprise coverage problem, as patients become aware that their policies don’t cover care in the same way they have in the past. We would also note that this same issue of higher patient financial obligations is affecting the delivery of health care in other ways. In a survey of our physicians nationally, we found that 7 of 10 emergency physicians reported seeing insured patients who said that they delayed care out of concern about high out of pocket expenses due to the nature of their insurance coverage.

None of these concerns would be alleviated by the proposed draft.

We completely agree that patients should not be subject to surprise bills when they are unknowingly treated by physicians who are not in their insurer’s network, and we acknowledge that there is a state interest in protecting patients from outlier charges. However, instead of empowering insurers to have complete autonomy in determining how much they will pay non-contracted, out-of-network emergency care providers, we strongly suggest a far more fair and transparent approach that places neither insurer nor provider in charge of determining payment rates. We urge you to consider amending your draft legislation by adopting language that would set a minimum benefit standard for out-of-network care



based on an appropriate percentile of a truly independent, robust, and transparent database of physician charges for the same services in the same geographic areas. Other states are utilizing such a database to effectively and fairly address the out-of-network payment issue.

We will look forward to working with you and other stakeholders on addressing these issues. Thank you for your time and consideration.

Sincerely,

Dr. Heather Hammerstedt, MD, MPH
President, Idaho Chapter of the American College of Emergency Physicians

Dr. Rebecca Parker, MD, FACEP
President, American College of Emergency Physicians

Dr. Timothy Seay, MD, FACEP
Chairman, EDPMA Board of Directors