American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

March 23, 2018

The Honorable Bill Cassidy, MD
520 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Cassidy:

On behalf of the American College of Emergency Physicians (ACEP) and our 38,000 members, thank you for the opportunity to share our comments and recommendations regarding your effort to better understand the costs of health care and improve price transparency and accountability for patients.

As you develop this initiative, we urge you to keep in mind issues that are unique to emergency medicine. In the emergency department, minutes and seconds matter and emergency physicians are often required to exercise their best clinical judgement quickly. Patients who have life-threatening illnesses and injuries obviously do not have the ability to shop around for the "lowest cost" provider. In delivering acute care, it would be impractical – or even impossible – to provide a patient with a list of procedures and their costs. Many of the procedures we perform are part of the patient's evaluation and workup, and the patient's ultimate diagnosis depends upon this work. Like you, we strongly believe that a patient's concern should be on receiving the appropriate care, rather than choosing their care based on cost.

Additionally, emergency physicians remain caught between two laws – the Emergency Medical Treatment and Labor Act (EMTALA) that guarantees access to emergency medical care for everyone, regardless of insurance status or ability to pay, and the Affordable Care Act (ACA), which includes emergency services as an essential benefit. Both laws have had the effect of increasing overall volume, while discouraging incentives for health plans to enter into fair and reasonable contracts to provide services at reasonable in-network rates. The majority of emergency physicians would prefer to practice in-network and ensure that patients are not subject to "surprise bills" or high out-of-network rates, but the current environment leaves both emergency physicians and their patients subject to the practices of insurance companies.

The requirements of EMTALA are mandatory and are unaffected by insurance status or payment considerations. In fact, there can be no signs posted in the emergency department regarding prepayment of fees or payment of co-pays and deductibles. To do so could lead patients to leave before receiving treatment and anything that dissuades them from receiving care may be construed as an EMTALA violation.

When conducting a medical screening exam in the emergency department as required by EMTALA, additional lab, imaging, and other services are often required. There is no way of knowing up-front what those ancillary services will cost the patient since they are provided by different physicians who have their own price structure and insurance policies, and who may or may not be part of the patient's insurance network.

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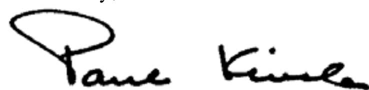
If we attempt to get that information prior to accessing those tests, that would not only be an EMTALA violation, but it could potentially cause the patient's health to deteriorate. The last thing we want to do is put our patients in a position of making life-or-death health care decisions based on costs, provided they are not already incapacitated and are fully able to make a rationale decision.

Once again, we deeply appreciate your attention to this important issue and your focus on improving price transparency for the benefit of our patients. We are grateful for the opportunity to share our response and stand ready to address any further questions you may have as this initiative continues. To better inform your request for input, our responses that follow for the most part address only emergency medical care, rather than the entire health care system.

Should you have any questions, please do not hesitate to contact Laura Wooster, ACEP's Associate Executive Director of Public Affairs at lwooster@acep.org.

Sincerely,



Paul D. Kivela, MD, MBA, FACEP
ACEP President

- **What information is currently available to consumers on prices, out-of-pocket costs, and quality?**

The mission of FAIR Health is to provide transparency to the health care and health insurance marketplaces. It was established in 2009 by then Attorney General of New York, Andrew Cuomo, in response to an investigation he had conducted against Ingenix and its parent company UnitedHealth Group. In 2008, Attorney General Cuomo had found that rates of health care charges maintained by Ingenix were lower than the actual costs of certain medical services. Ingenix and Attorney General Cuomo reached an agreement that UnitedHealth Group and Ingenix would help fund a non-profit entity that would develop a new healthcare pricing database. Out of this agreement came the creation of FAIR Health.

The FAIR Health database includes data on claims from 150 million covered lives and 16 billion medical procedures, and these figures are growing. Claims include dental claims, but not prescription drug claims. The database contains claims from private insurance in all 50 States, and, through the Qualified Entity Program, has access to all Medicate Parts A, B, and D claims data. the database consists of claims for the most recent 12 months available. FAIR Health provides analytical resources and tools that serve the full spectrum of healthcare stakeholders: payers, hospitals and healthcare facilities, physicians, the Government, and consumers.

FAIR Health has been designated as an official benchmark for determining out-of-network reimbursement in both New York and Connecticut. In New York, the State Department of Financial Services, which provides oversight to insurance companies, issued guidance implementing Part H of Chapter 60 of the Laws of 2014 that identifies FAIR Health as an authorized, "independent source" for health plans to determine the "usual and customary cost" for out-of-network services. If health plans choose to use a source other than FAIR Health for determining the usual and customary cost, they must seek approval from the State Department of Financial Services.

With respect to consumers, FAIR Health maintains a website and mobile apps that uses data from its vast database to help people understand the costs of medical and dentist services and procedures in their specific geographic area. For example, if a person wanted to know the cost of getting a stomach ulcer removed, he or she could find out the average in-network and out-of-network cost in that person's zip code.

Beyond the FAIR Health database, there is little to no price data available to consumers that is provided in a clear, consistent, informative, and easily-accessible manner. While there are some attempts to rectify this issue, including all payer claims databases (APCDs) or insurers' own proprietary offerings to members such as price estimation tools, the fact remains that none of the available tools fully explain the costs of care. Further, not all of these tools are available to all consumers. The availability, requirements, and capabilities of APCDs, for example, vary widely from state to state (other challenges regarding these databases are further detailed in the section below regarding APCDs). Determining prices, out-of-pocket costs, and quality represents a significant burden on the consumer.

Currently, the FAIR Health database represents the most consumer-friendly tool to ascertain regional costs for procedures, both in-network and out-of-network. However, there are still many other variables that exist in providing care that are may not be reflected depending on the severity or complexity of a patient's particular case.

- **What information is not currently available, but should be made available to empower consumers, reduce costs, increase quality, and improve the system?**

  ACEP believes that it is the responsibility of insurers to clearly provide information to consumers about the potential costs of seeking emergency care under their particular coverage. Providers in the emergency department can participate by helping patients interpret their co-sharing responsibilities, but the onus should be on insurers to make these costs transparent to patients. Ultimately, while providers and hospitals could provide raw pricing information upfront to patients, without information from insurers, it is of little use.

  Patients should be able to know if their emergency physician is in-network, and should not be financially penalized if they receive care from an out-of-network provider. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. Patients should also be provided with reasonable and timely access to in-network physicians.

  One barrier that affects our patients' access to high-quality, affordable care is that insurance companies do not release or make public their contracted, in-network rates for individual procedures or services, or even their out-of-network coverage rates. As such, under the current system what is actually charged is virtually never what is paid, leaving the consumer unable to compare prices and further distorting the true costs of care.

- **What role should the cash price play in greater transparency? How should this be defined?**

  The so-called "cash price" as it exists currently today will have little value in trying to improve transparency for health care consumers. If the consumer has private health insurance coverage and receives care from an in-network provider, the price of that care will be dictated by the rates their insurer has negotiated with that provider. This, of course, is different from the *cost* of that care to the consumer, which will be also based on their particular cost-sharing arrangement under their coverage, and deductible amounts.

  Should they have private coverage but receive care from an out-of-network provider, then the price of that care will be dictated by whatever method their insurer uses to determine the usual and customary amount. The *cost* to the consumer for that care will depend on whether they reside in a state that allows balance billing, the difference between the provider's charge and that usual and customary amount, and their particular deductible.

  For these reasons, we note that awareness of pricing information is not always informative.

- **Different states have used different methods to work towards price transparency:**
  - **Colorado – all providers publish paid amounts related to both in-patient and out-patient services.**
  - **Kentucky – requires hospitals and ambulatory surgery centers to submit data on health care charges, quality, and outcomes that includes diagnosis-specific or procedure-specific comparisons.**
  - **Virginia – performs an annual survey of carriers offering private group health insurance policies, to determine the reimbursement that is paid for a minimum of 25 most frequently reported health care services or the treatment of certain conditions or diseases.**
  - **Maryland – requires hospitals to provide and post the pricing information for the most common medical treatments in all hospitals, including the number of cases, the average charge per case and the average charge per day.**

**What are the pros and cons of these different state approaches? What is the best quality and price information to collect for consumers and businesses?**

As is clear just from the four state approaches described above, states approach price transparency methods in many different ways, and in some cases have gone through several iterations of different approaches. Because of this, as well as inherent differences between states, it is difficult to assess the direct impact of a particular approach, nor can it be extrapolated to another state.

With regard to emergency medicine, one approach that has provided greater predictability for patients who receive emergency care is that of Connecticut. Under state law (Public Act 15-146), it sets the payment for out-of-network emergency services as the greater of:

1) the allowed amount for in-network services,
2) the usual and customary reasonable rate for such services (defined by statute 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 via a benchmarking database run by a non-profit); or,
3) the amount Medicare would pay for the service.

On June 29, 2016, the State of Connecticut Insurance Department issued guidance to insurance companies defining the "usual, customary and reasonable rate" as "the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported by FAIR Health, Inc."

- **Who should be responsible for providing pricing information and who should share the information with consumers?**

As stated above, ACEP believes that it is the responsibility of insurers to provide clear information about prices to their consumers. ACEP is particularly concerned about the lack of transparency around out-of-network rates for services. ACEP has pushed for years to have these rates be determined through a transparent process, using publicly verifiable data. However, regulators have allowed a lack of enforceable and transparent standards for out-of-network benefits in legislation and regulations governing health plan coverage for emergency care services. Many insurers use the usual, customary, and reasonable ("UCR") amount to determine their out-of-network rates. We strongly believe that when determining UCR charges, insurers should use a database of geographically comparable usual and customary charges maintained by an independent non-profit organization that is not affiliated, financially supported and/or otherwise supported by an issuer or by a supplier – such as Fair Health. Such a database should be transparent, statistically valid, and protected against conflict of interest. In rural areas, to the extent the data for usual and customary charges is not sufficient to make a determination, issuers may combine similarly situated usual and customary data, provided, however, that the methodologies and determinations shall be fully disclosable upon request. Establishing a uniform national methodology for insurers to calculate payments for out-of-network emergency services that is based on the reasonable market value of emergency services would protect the financial viability of emergency care in our country.

- **What role should all-payer claims databases play in increasing price and quality transparency? What barriers currently exist to utilizing these tools?**

While all-payer claims databases offer potential in collecting and analyzing data, there are a number of issues limiting their effectiveness in increasing price and quality transparency. As noted earlier, APCDs currently

exist in just over a dozen states, and in different forms – some are mandatory, others exist with voluntary submission. See Appendix B of a report prepared by the University of Chicago's NORC for a summary of APCD features by state as of May, 2017.

And though the term "All Payer Claims Database" implies that *all* payers are submitting data, there are many exceptions. APCDs may not capture uninsured or uncompensated care (such as frequently occurs in emergency departments), or care provided under the auspices of federal programs such as TRICARE or the U.S. Department of Veterans Affairs, patients who receive care in one state but reside in a neighboring state, or even Medicare and Medicaid populations, among others. Additionally, per the U.S. Supreme Court's ruling in *Gobeille v. Liberty Mutual Insurance Co.*, the Court held that states may not require ERISA plans to submit their data to the state's APCD (though such data may still be submitted voluntarily).

- **How do we advance greater awareness and usage of quality information paired with appropriate pricing information?**

ACEP believes that we should be measuring and reporting quality performance in ways that are meaningful to both patients and providers. Through ACEP's Qualified Clinical Data Registry (QCDR), the Clinical Emergency Data Registry (CEDR), we have been developing measures that emergency physicians can use to improve patient care, while fulfilling the requirements of the Quality Payment Program. As we think about how to use quality data effectively, important issues to consider are whether the data is reliable and attributable to specific clinicians. We must find a balance between transparency and providing information that will be overwhelming or confusing to the public.

While CMS has posting performance data on Physician Compare website for years, we still have concerns about the accuracy of the data and how it is being used and interpreted by Medicare beneficiaries. CMS has recently emphasized the public reporting of patient experience measures, such as the Consumer Assessment of Healthcare Providers Survey (CAHPS). While we support the value of patient experience measures, we strongly object to attributing the scores from the CAHPS to any emergency care professionals under any circumstance, as this instrument was neither developed with the intention of measuring emergency care nor validated in the emergency department. A patient experience survey tailored to emergency medicine, the Emergency Department Patient Experiences with Care (EDPEC), is still under development by CMS, and it is unclear whether or when it will be implemented. Under the Quality Payment Program (QPP), performance on cost and quality are not inextricably linked. Like the Value Modifier before it, the QPP includes separate quality and cost measures and categories of performance. We believe that value is a function of both quality and cost, and physicians cannot be accurately evaluated on value if the cost and quality measures are not aligned. However, before aligning these cost and quality measures, it is important to address some issues with accurately measuring "cost." Many of the cost measures used in the Value Modifier did not adequately attribute costs to emergency physicians and other specialists. ACEP also has raised concerns in the past about the validity, risk adjustment methodology, and the actionability of some of these measures. CMS has removed most of the Value Modifier cost measures from the QPP and is now engaging on campaign to develop specialty specific episode-based cost measures. ACEP supports the agency on this endeavor.

- **How do we ensure that in making information available we do not place unnecessary or additional burdens on health care stakeholders?**

The EMTALA regulation and the prudent layperson standard require that ED physicians provide medical screening and care for any patient who seeks services from an ED. These protections ensure that patients receive care regardless of insurance coverage. As a result of these two standards insurance companies have no

incentives to negotiate fair reimbursement rates because care is guaranteed regardless of reimbursement. This practice leaves hospitals and EDs confused and puts a greater burden on patients.

If providers can achieve a fair reimbursement, they generally prefer to be in-network, as it provides predictability of revenue and, more importantly, much less confusion and potential unexpected financial burden for patients than when out of network. Being out of network obscures transparency, claims adjudication, requirements, and a level playing field, which are all elements that would foster negotiation between plans and providers.

- **What current regulatory barriers exist within the health care system that should be eliminated in order to make it less burdensome and more cost-efficient for stakeholders to provide high-quality care to patients?**

As you may know, Congress enacted a provision in the Affordable Care Act forbidding insurers from imposing coverage limitations on out-of-network emergency services that are more restrictive than any limitations imposed on in-network emergency services, and mandating equal patient cost-sharing for in-network and out-of-network emergency services.[1] In 2010, the Obama Administration promulgated an interim final rule (IFR) with comment period, issued by the Departments of Health & Human Services, Justice, and Labor (Departments), to implement this provision on out-of-network emergency services. The Departments noted that the statute does not require insurers to pay any amounts that out-of-network providers balance bill to patients, and the Departments interpreted the statute to require that a "reasonable amount be paid before a patient becomes responsible for a balance billing amount," as determined by "some objective standard."[2] The Departments stated that a reasonable payment is necessary because, otherwise, insurers might establish extremely low payment rates for out-of-network emergency services, thus subjecting patients to very high balance bills. Therefore, in order to set such an objective standard, the IFR established a "greatest of three" (GOT) methodology for determining payment for out-of-network emergency services in which the insurer must pay <u>the greatest</u> of the following:

1) the insurer's in-network amount;
2) the amount calculated by the same method the plan generally uses for out-of-network services, such as the usual, customary, and reasonable ("UCR") amount; or,
3) the Medicare amount.

The preamble to the IFR described the second of the GOT amounts as the same method the plan generally uses, such as UCR "charges."

In our respective comment letters responding to the IFR in August of 2010, ACEP, the American Medical Association, the American Hospital Association, and several other organizations all expressed concerns about the GOT standards. In particular, the second of the GOT standards is subject to insurer manipulation unless it is verifiable, and the term "usual, customary, and reasonable amount" is not an objective standard for calculating out-of-network payments because it is not defined. Accordingly, we recommended that CCIIO require both that insurers use UCR *charges* when determining the second of the GOT standards, and that the data supporting the calculation be subject to independent verification. These issues are crucial because Medicare rates are some of the lowest in the industry, and in-network amounts are also depressed because in-network providers accept lower reimbursement in exchange for the volume and other benefits that accompany in-network status. Thus, the second of the GOT standards, if calculated fairly and accurately, will nearly always be the greatest of the three and will determine the out-of-network payment.

[1] 42 U.S.C. § 300gg-19a(b)
[2] 75 Fed. Reg. 37,188, 37,194 (June 28, 2010).

The current GOT regulation represents the greatest threat to the financial viability of the emergency medicine profession and to patient access to qualified emergency physicians and emergency department on-call specialists than any other federal regulation to date. In fact, emergency physicians have seen payments for out-of-network services drop significantly since the GOT regulation was issued in 2010. By giving insurers an incentive not to contract for emergency services, the greatest of three method may impact the ability of EDs to provide care to patients due to inadequate reimbursements that do not cover the cost of stabilizing and treating patients who present at the ED.

- **How can our health care system better utilize big data, including information from the Medicare, Medicaid, and other public health programs, to drive better quality outcomes at lower costs?**

There is an enormous amount of data available from CMS, but like any data, its utility is dependent on context. Over the last few years, CMS has released data on Medicare utilization and payments down to the National Provider Identifier (NPI) level. Furthermore, there established programs, such as the Qualified Entity program, that allow organizations to gain access to Medicare data. With such availability of data, there is a concern that it is being interpreted and used appropriately. Now, as the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) and the Quality Payment Program (QPP) continues, more data regarding the shift from volume-based to value-based care should also be increasingly available and relevant to help inform efforts like this one.

As noted in our response in the previous question, Medicare rates are among the lowest in the industry and Medicaid rates even lower, so we would urge Congress to consider how these rates could significantly skew the average. Additionally, many federal programs cover targeted populations where age and other demographic considerations may not accurately reflect the typical privately insured patient population.

- **What other common-sense policies should be considered in order to empower patients and lower health care costs?**

We urge Congress to keep in mind the unique nature of emergency medicine as it addresses the issue of price transparency. ED care is distinctive in the way it functions and how providers charge for their services. Under EMTALA, ED physicians must provide as much care as needed to stabilize patients. Due to the nature of emergency medicine, the types of treatments patients will need or receive are unknown. The "prudent layperson" standard ensures that patients receive care in the ED without needing prior authorization from a health plan.

The care emergency physicians provide therefore varies widely both in terms of condition and acuity, is dependent on the result of the medical screening exam, and is delivered under unique federal mandates and regulations not present in other areas of medicine. To this last point in particular, emergency physicians cannot discuss costs with patients who require diagnostic testing or imaging to complete a medical screening exam, as this would constitute an EMTALA violation. It would not be feasible to list out the wide array of services that could be potentially necessary as part of an emergency department visit, as the purpose of the medical screening exam itself is to determine the next appropriate step in the care delivery.

Most importantly, we do not want patients basing potentially life-or-death decisions on costs. We recognize that costs already factor into some patients' decisions, as emergency departments too often see patients who have foregone necessary care until it has unfortunately become an emergency, but we must not exacerbate this ongoing concern.