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**MACEP COMMENTS TO THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES AND THE HEALTH POLICY COMMISSION REGARDING REIMBURSEMENT OF OUT-OF-NETWORK SERVICES LISTENING SESSIONS 6/10/21 AND 6/24/21**
**June 29, 2021**

The Massachusetts College of Emergency Physicians (MACEP) appreciates the Listening Sessions convened by the Executive Office of Health and Human Services (EOHHS) and the Health Policy Commission (HPC) as part of Chapter 260 of the Acts of 2020's charge to issue recommendations relative to Out-of-Network (OON) reimbursement for emergency and non-emergency services.

Emergency physicians differ from any other specialty relative to contracting with health insurers. We are subject to the federal EMTALA law which involves 100% of our patients. Our doors are open 24/7/365, and our departments are a critically necessary hub for accessing behavioral health and substance use disorder services, let alone so many other emergent conditions like strokes, heart attacks, trauma and a global pandemic. Under EMTALA, we are the only physician specialists that can never turn away or refuse to treat a patient who comes through our doors, regardless of insurance status or ability to pay for services. We are unique in this regard and proud of this commitment to the public health. However, when insurers do not pay fairly for the costs of care, emergency physician groups are forced to turn to hospitals to subsidize the care provided or run the risk of reducing services or ultimately closing their emergency department f doors. EMTALA is a distinction that separates emergency medicine from all other specialties in negotiations with health insurers. An emergency physician group can walk away from a contract that offers inadequate rates but cannot walk away from patients, ethically or legally.

**MACEP urges EOHHS and the HPC to recommend that the legislature allow the federal No Surprises Act, signed into law Dec 27, 2020, to take effect. By doing so, all commercially insured patients in Massachusetts would be protected from surprise medical bills, and a fair, uniform system would be enacted to determine the reimbursement rate paid by insurers to hospitals and physicians for the services provided.**

Among many other provisions, the No Surprises Act:

- Protects patients from receiving surprise medical bills resulting from gaps in coverage for emergency services and certain services provided by OON clinicians at in-network facilities, including by air ambulances.
- Holds patients liable only for their in-network cost-sharing amount, while giving providers and insurers an opportunity to negotiate reimbursement.

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- Allows providers and insurers to access an **independent dispute resolution** process in the event disputes arise around reimbursement. The legislation does not set a benchmark reimbursement amount.
- Requires both providers and health plans to assist patients in accessing health care cost information.

Attached is a more detailed summary of the federal law as it applies to emergency care.

The long, oftentimes laborious, but always thoughtful negotiations that went into the federal law allows for cost savings, predictability across all plans, and consistency in the Massachusetts health insurance market.

The Congressional Budget Office estimates the federal law will save approximately $17 billion over the next 10 years and will bring down the outliers. Compare this value to the time and financial considerations of creating and implementing a new state law in Massachusetts. For this reason, many states are taking a wait and see approach. Others are moving to undo what they've already done to ensure consistency with federal law.

**Another important point in favor of the No Surprises Act is that it applies to employer, self-funded plans that are exempt from state insurance laws under the Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §1144, and to state-regulated plans if a state does not have its own balanced billing law.** This is an important consideration, given that approximately 60% of the health plans in Massachusetts are ERISA exempt. Moreover, most states believe that ERISA impedes their ability to ensure adequate consumer protections, collect data on all health plan participants uniformly, or enact health cost reductions, and thus, is an obstacle to their ability to effectively manage their health care markets. **Allowing the federal No Surprises Act is the only way to ensure consistency among <u>all</u> commercially insured plans in Massachusetts and to protect all patients equally**.

**MACEP is extremely concerned that state legislative action on this issue would be risky for emergency medicine, especially at this time when we are just emerging from a national healthcare crisis.** Emergency physicians have been on the front lines of the pandemic, and the emotional and financial costs have been high. Hospital revenues and patient volume are down, resulting in the threat of further emergency department coverage cutbacks. Over the past decade there have been multiple hospital ED closures and, more recently, layoffs due to the financial toll on hospitals by the pandemic. Passing punitive legislation on OON services that favors insurance companies over front-line providers would make this situation even worse, creating significant financial pressure on smaller, rural and community hospital who lack leverage to negotiate fair rates. The risk of unintended consequences is high and could result in increased consolidation of hospitals, increased cost and reduced access to care for patients.

A recent article by Commonwealth Magazine, citing data recently released by the Center for Health Information and Analysis (CHIA), noted that "Even as Massachusetts hospitals were coping with an influx of COVID-19 patients this spring, they were losing massive amounts of money. While some hospitals got large sums of federal relief money, a new report from the Center for Health Information and Analysis shows the aid was nowhere near enough to offset the losses (https://commonwealthmagazine.org/health-care/massachusetts-hospitals-bleeding-money). The Massachusetts Health and Hospital Association said in a statement that the report paints a clear picture of the serious economic challenges our hospitals are facing. "Massachusetts hospitals continue to grapple with the immense losses brought on by COVID-19, which threaten the stability of many healthcare organizations – especially community and safety net providers,"

Standing in stark contrast to the financial picture for hospitals and providers, health insurers across the nation are reporting record high profits, in some cases, double what they were a year ago, and kicking in a provision of the Affordable Care Act requiring rebates to consumers. (https://www.nytimes.com/2020/08/05/health/covid-insurance-profits.html).

During the first Listening Session, MACEP heard the insurers supporting a recommendation of 135% of Medicare. MACEP strongly opposes that recommendation and does not support setting rates for OON services based the federal Medicare reimbursement fee schedule. Medicare is an inappropriate benchmark for payment by commercial insurers. Medicare is not currently, and was never intended to be, a source for commercial physician payment. **Medicare rates have no relationship to fair market value or the cost of providing care in the emergency setting** and are based on federal budgetary considerations. OON billing solutions based upon Medicare rates will cause long-term damage to the health care delivery system in Massachusetts.

Attached is an American College of Emergency Physicians (ACEP) fact sheet detailing the growing disparity between Medicare rates and inflation between 1992 and 2016, noting that by 2016, Medicare rates were less than half of the Bureau of Labor Statistics CPI-U.

Evidence of the inadequacy of 135% of Medicare can be found in a study by the **RAND Corporation**, which analyses the potential impact of OON payment caps on acute care hospitals. The RAND study analyzed the impact of a New Jersey law that capped payments from commercial insurers between 100% to 250% of Medicare. That study concluded that "for every 1 percent reduction in OON prices, in-network rates will decline 0.5 percent. Capping OON payments at 250 percent of Medicare rates would reduce commercial payments by about 12 percent and render approximately 75 percent of all hospitals unprofitable." The report went on to state that **"Caps on out-of-network payments strengthen health plans' leverage."**

It is worthwhile to look at the impact of California's 2016 law. In a June 20, 2019 letter from the California Medical Association to the U.S. Senate Health, Education, Labor and Pensions Committee, David H. Aizuss, M.D. states: "**Unlike the surprise billing law in New York, California's law did not appropriately incentivize insurers and physicians to enter into contracts to protect adequate physician networks and patient access to care**. Insurers across the state are now refusing to renew longstanding contracts, suddenly initiating contract terminations or demanding significant reductions in physician reimbursement rates to discourage physicians from contracting. California insurers have decided that they can just pay the low benchmark payment rate in the law and forego contracts with physicians. These insurance company actions are a direct result of the California surprise billing laws."

**While MACEP understands and supports no balance billing for any health care consumer, we feel strongly that impeding the ability for emergency providers to negotiate for fair reimbursement is not an appropriate response to the OON issue in Massachusetts**. It will hurt patients and their ability to access community and critical access hospitals, which will be forced to reduce staffing, sacrifice quality of care, subsidize their emergency departments (despite already operating on razor-thin margins), or close their doors altogether. In short, implementing Medicare reimbursement, or even a system based on a modicum reimbursement factor above Medicare rates, would bankrupt many emergency practices and departments across Massachusetts.

Finally, MACEP would also like to address the insurers stated claims on the first Listening Session that to do nothing would result in huge increases in OON reimbursement based on charges. Nothing could be further from the truth. First, of the few OON claims in Massachusetts, most are actually out of network providers at

in-network facilities. In such cases, the in-network rate generally applies and the patient incurs no additional co-pays or deductibles. Moreover, the federal OON law is not based on charges, and in fact, charge data, as well as public payor data, are prohibited from consideration in the independent resolution process, so as to remove outliers on each end.

In conclusion, **MACEP supports the federal No Surprises Act** as a well thought out, nationally supported approach to OON care that satisfies the following fundamental principles strongly supported by MACEP:

1. **Take the patient out of the middle**. Patients should never get stuck with unexpected bills, especially for emergency care. When a patient receives out-of-network emergency care, the emergency services provider should not balance bill the patient. Patient responsibility for out of network emergency care should be limited to in network cost sharing rates;

2. **Increase Transparency** of the limitations of insurance coverage. Much of what is called to "surprise billing" is actually a "surprise lack of coverage" due to the growth of limited or narrow network insurance plans;

3. **Ensure fair reimbursement** for physician services; and

4. **Implement a timely dispute resolution process** for resolving payment disputes when the insurer and provider disagree.

For all of the above reasons, **MACEP urges EOHHS and the HPC to recommend that the legislature allow the federal No Surprise Act to take effect in Massachusetts**