American College of Emergency Physicians®

ALASKA CHAPTER

ADVANCING EMERGENCY CARE

SB 129: "An Act relating to emergency services and balance billing; relating to the determination by an insurer of a final payment for a covered service or supply; and annulling regulations relating to determination by an insurer of a final payment for a covered service or supply based on geographical areas."

Representing more than 80% of the emergency physicians providing emergency medical care to the people of our state, the Alaska Chapter of the American College of Emergency Physicians writes today to respectfully request that the state legislature protect the emergency healthcare safety net in Alaska. It is a fragile net that has been carefully constructed by patient advocates and health care providers, and it is a net that saves lives. SB129 would put at risk this safety net.

Recommendations:

- The 80th Percentile Rule must remain in effect and be linked to an independent non-industry funded database such as the Fair Health Consumer database. We welcome a ban on balance billing if the 80th Percentile Rule is kept in place as this would support fair payment without placing patients in the middle.
- We would like to share model legislation with our legislators to address the unfortunate surprise coverage gaps that have been created by insurance carriers with the proliferation of high deductible plans that leave patients underinsured. This model legislation improves patient protection and creates a Minimum Benefit Standard.
- We encourage the state to require that the insurance companies be responsible for collecting their high deductibles. Physicians and hospitals should not be in this role. Clinicians and hospitals should bill insurers directly and the insurer should be responsible for collecting whatever cost-sharing they require. This would simplify and increase transparency in the billing practice, again saving cost to the system. This will decrease the amount of uncompensated care and administrative costs, allowing physicians and hospitals to bring down charges.

As you know, emergency departments provide a unique and critical role in our health care system. We are proud that as emergency physicians we care for all patients that walk through our department doors regardless of any ability to pay for the care they receive. This is our ethical duty to our patients. It is, appropriately, also required by law under a federal mandate known as EMTALA, the Emergency Medicine Treatment and Labor Act (42 U.S.C. 1395dd). We believe in that law and its mandate that any 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 embrace this requirement and recognize it as the essential role of our field. However, it does mean that emergency physicians provide more uncompensated care than other physicians.

While we provide health care regardless of the patient's ability to pay, that does not mean that we can ignore the potential impact of legislation. SB129 proposes eliminating the 80th Percentile Rule while maintaining balance billing and linking reimbursement to Medicare rates. These steps will lead to destabilizing the Alaska emergency care network, the safety net of our state. This will increase costs of care for Alaskans. We responded last year with similar testimony when the Division of Insurance looked at the 80th Percentile Rule as a whole. We continue to advocate that Alaska needs to protect our ability to provide excellent emergency care to our patients, and we believe that this can be achieved in ways that will not have the adverse consequences of this legislation. We are happy to partner with the State of Alaska to find meaningful solutions to control costs that put the patients' needs first. SB 129 will not achieve that goal.

Emergency Physician care charges in Alaska are consistent with those in the Lower 48.

The Fair Health Consumer database (www.fairhealthconsumer.com) can be used to compare charges across the country. One example we can use is the "99285" service which is billed for the most complex cases in emergency medicine. That service has a charge at the 80th percentile in Anchorage of $1,021. In Seattle that same service is $1,120, in Dallas $1,488, in Miami $1,793, and in New Orleans it is $1,924. A more detailed study including both rural and urban areas reveals that Alaska charges are well within the range of what is seen in other parts of the United States.

In addition, most emergency physicians are in network for all major healthcare insurance plans in Alaska. The 80th Percentile Rule protects us from needing to engage in balance billing, and it provides an appropriate incentive for health plans to contract with physicians fairly to keep them in network. It also protects our patients from receiving surprise balance bills from EM providers.

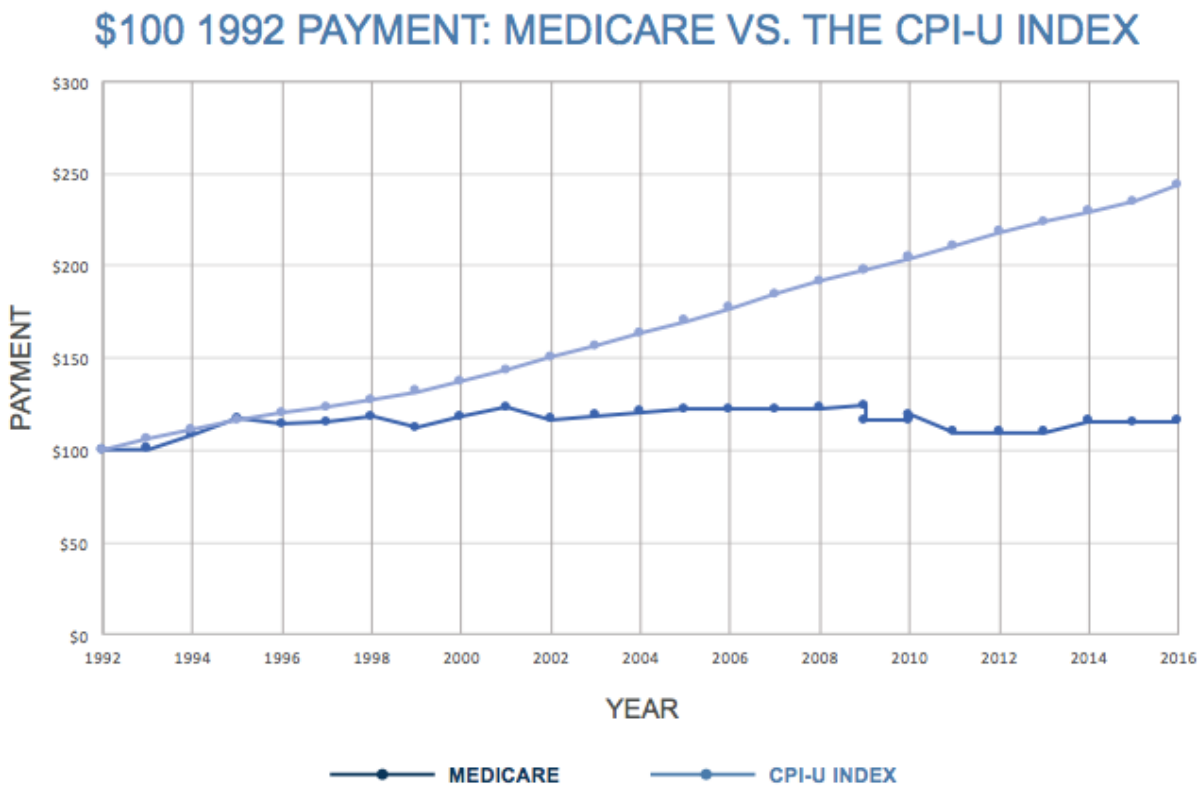
We acknowledge the problem of healthcare costs in Alaska and want to work toward a solution.

Though our charges are comparable to the Lower 48, including Seattle, we realize that healthcare costs are deeply concerning. We hear rumors of horrific bills encountered for emergency care when a specialist evaluated a patient and was unexpectedly out of network and then the patient was "balanced billed" the excess. We know these bills do not come from our emergency providers, but we too are horrified if our patients are harmed by their bills.

After the implementation of the Affordable Care Act (ACA), more patients have elected to be covered by high deductible plans. This means that even with insurance, some patients arrive and obtain care but are unable to pay their bills because their deductibles are so high. Patients now have to pay monthly insurance payments that are the size of a home mortgage, but when they have a medical problem they get no payment from their insurance. Please know that we continue to care for these patients although we often never see payment. Insurers are effectively transferring costs on to their patients and the physicians that treat them.

Emergency physicians are only 4% of physicians in this country but we provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients. We are accustomed to caring for patients who have no insurance and never pay their bill. We need to keep our emergency departments open with the appropriate subspecialty backup. To do this we need a system for fair compensation so we can continue to care for our patients.

Linking payment to Medicare is flawed.



Linking fair payment to Medicare is a flawed strategy. Healthcare reimbursement should not be linked to Medicare regardless of what excess percentage is allowed. Medicare rates do not represent fair market value and fluctuate based on federal politics and budgetary needs and not the cost of delivering care. Currently in Alaska providing medical care to Medicare patients is not a

financially viable business. The seniors in our community struggle to obtain access as a direct result of this poor reimbursement. Few outpatient providers accept Medicare patients into their practice. I know this because we care for them in our emergency departments when they miss the opportunity of timely access to outpatient care. Linking reimbursement for emergency care to Medicare leads our safety net to a path of insolvency. As seen clearly in this graph, Medicare rates have not kept up with even general inflation. Between 1992 and 2016 Medicare rates decreased by 43% when adjusted by inflation. When Medicare introduced those rates in 1992 they were already 50% of what the usual and customary charges were at that time.

Our Safety Net is Already Limited.

Most Alaskans do not realize the limits of our medical network until they need emergency care in response to a severe accident or life-threatening illness. Our emergency care network now has two level-two trauma centers in Anchorage, multiple centers that can provide excellent acute cardiac care and high quality acute stroke care, and a pediatric emergency center. However, even in our metropolitan area the care we can offer is limited in several key areas, and too often we must send patients to Seattle. We have no burn unit in Alaska, and only two orthopedic surgeons capable of dealing with complex pelvic injuries. We often have no cardio-thoracic surgery capabilities in the state and have limited on call specialists outside of the Anchorage area. We are grateful to our amazing air transport teams for this capability but we hope you understand that sending patients on a six-hour flight to find care elsewhere comes at a cost. Patients die every year in flights on their way to Seattle for care that they needed immediately but could not receive in Alaska. The economic transport cost is high, but the human cost is much higher when a flight delays care.

While we applaud SB 129's efforts to reduce costs, we know it will undermine our safety net. It will lead to fewer specialists available to be on call and more patients unable to get the care they urgently need. It will increase the already significant challenges in recruiting and retaining physicians throughout the State of Alaska when they are most in need: in an emergency. It will put our rural hospitals at great risk and decrease emergency care accessibility. As a result, severely injured or ill patients in Alaska will have decreased chances of survival and increased chance of expensive and time-intensive transfer both in state and to Seattle.

Emergency physicians have a unique legal and ethical requirement to care for all who enter the emergency department. Other specialists do not have the same requirements.

Notably, surgeons and other highly-trained specialists who play a vital role in keeping patients alive during emergencies are NOT required by law to provide on-call support. They need some other incentive. And currently that incentive is appropriate reimbursement.

There is no way to legally require a surgeon to be on call and available in the event of a life-threatening emergency. The only tool available is reimbursement and the conscience of the individual surgeon. This is an unfortunate reality. And we see it affect the lives of patients in our care.

Today, a child in Anchorage who slips on the ice and develops an epidural bleed, a life-threatening bleed within their skull, will be able to be seen rapidly by an on-call neurosurgeon who can save the child's life with a prompt procedure. Without a neurosurgeon on call locally this patient would die. A transfer to Seattle even at its most expedient would not be rapid enough to save this patient.

We do not want to see Alaskans lose opportunities to live and regain health because of a convenient political "solution."

ACEP shares the goal of reducing costs.

The Alaska Chapter of the American College of Emergency Physicians represents more than 80% of emergency physicians practicing in the State of Alaska. Our physicians practice in both very remote and very urban areas of our State maintaining the safety net of our healthcare system 24 hours a day, 7 days a week, 365 days a year.

Our chapter has been actively working with state through Medicaid Reform Bill SB74 on the Emergency Department Coordination Project (EDCP). **Our goal has been to enhance the delivery of medical care to make it both higher-quality and more cost-effective.** The EDCP is modeled on a project from Washington State that implemented "7 best practices" that were documented to save the state $33 million in Medicaid expenditures annually. We have adapted these practices to the unique needs of Alaska and are in the process of rolling them out with a goal of achieving similar cost savings. We do this knowing that decreased emergency department utilization will lead to decreased reimbursement for emergency physicians.

It is often pointed out that 5% of the patients account for 50% of the cost to the system and we are working with the state on tools to address this. The Emergency Department Information Exchange (EDIE) is being implemented to coordinate care and avoid repeat testing on our high utilizers. We need to develop a system that helps bring the right care to the right patients at the right time. We can improve the cost of healthcare in this State without undermining a system that is functioning.

Emergency physicians have worked with Dr. Jay Butler, the Chief Medical Officer for the Alaska Department of Health and Social Services (DHSS) and other state officials to address the opiate epidemic. We have supported mandatory use of the Prescription Drug Monitoring Database for prescriptions greater than 3 days. We have written prescribing guidelines for emergency physicians. Emergency physicians are volunteering to partner with the US district attorneys' office to do education in high schools about the opiate epidemic. These initiatives are all focused on decreasing inappropriate access and use of prescription and street opiates, and as a result save lives and decrease emergency medical costs.

Cutting physician payments does not lead to reduced patient costs.

At a recent forum healthcare policy expert Uwe Reinhardt was quoted as saying that in our country we do not over utilize healthcare, we just overpay. However, Reinhardt did not believe that cutting physician reimbursement is the solution. He wrote: "Cutting doctors' take-home pay would not really solve the American cost crisis," it would "…return for a wholly demoralized medical profession to which we so often look to save our lives. It strikes me as a poor strategy." Reinhardt suggested that high costs of prescription drugs and the spending required to deal with insurers were tremendous burdens. He noted, "Our hospitals spend twice as much on administration as any hospital anywhere in the world because of all of this complexity." He pointed out that if our nation cut the cost of health care administration in half the savings would be able to insure everyone in the country (NYTIMES 11/15/2015)

It would appear the system is full of opportunities to trim costs. When individuals and groups purchase healthcare plans we pay 5% of premium to a broker. When an individual purchases government required healthcare for their family of 4 is it reasonable to have to pay $1000 administrative fee just for the transaction?

Recently we have seen the orthopedists in Anchorage contract with Premera substantially lower healthcare expenditures for orthopedic care. It is interesting that Premera raised rates on group healthcare plans as they paid physicians less and recorded record profits in Alaska. Efforts like this may allow insurance companies to erode local access to care while doing nothing to reduce healthcare costs to individuals.

Thank you,

Ben Shelton, MD, President AK-ACEP

Anne Zink, MD, Immediate Past President, AK-ACEP

Visit www.alaskaacep.org to learn more.