Government/National Affairs Committee

Update from the Government and National Affairs Committee

Andy Walker, MD FAAEM
Chair, Government and National Affairs Committee

Like most AAEM committees, the GNA Committee does most of its business via email. However, we had an energetic and productive in-person meeting on April 8, 2018, at the Academy's Scientific Assembly in San Diego. The main topics of conversation were attempts by the insurance industry to enhance its profits at the expense of the nation's medical safety net — emergency departments (EDs) and emergency physicians.

The main way insurers are attempting to increase profits is to shift more costs onto their clients — our patients — by increasing the percentage of medical costs patients must pay out of pocket and reducing the percentage paid by the insurer. One way to do this is to move patients to high-deductible policies, the other is to make it harder for patients to find an in-network provider, since every policy stipulates that the insurer is liable for a much lower percentage of the bill if the patient uses an out-of-network physician or hospital.

Since insurers know emergency physicians and EDs are legally bound by EMTALA to take care of every patient first and seek payment later, emergency medicine groups are particularly vulnerable to insurance companies that demand intolerable fee discounts in order to be in-network. Unlike office-based specialists, we cannot screen out and turn away out-of-network patients. We have no bargaining leverage at all, except for the threat to stay out-of-network and bill the insurer at the "usual and customary" rate, which is higher than the discounted in-network rate.

At the same time insurers have been driving EM groups to stay out-of-network, however, they have been working in state legislatures to cap the out-of-network fees hospital EDs and emergency physicians can charge. The insurance industry has already won in a few states; been turned back at least temporarily in many, including my home state of Tennessee; and been defeated outright in Connecticut, which passed a bill that protects ED patients from steep out-of-pocket costs and shifts the burden back where it belongs – with insurers, rather than emergency physicians.

While AAEM's leadership, the GNA Committee, and the Academy's representative in DC – lobbying firm Williams and Jensen – continue to keep an eye on the situation, the insurance industry has little chance of getting the victory it hoped for in Washington on this issue. All the action on out-of-network fee caps will be at the state level. **I urge you to contact your state legislators about this now and begin educating them on how uniquely this affects EDs and emergency physicians and threatens to unravel the medical safety net.** Almost none of them realize that, because of EMTALA, we can't tell patients we are out-of-network with their insurer (or even ask about insurance or payment) until after the medical screening exam is complete and any emergency medical condition found has been "resolved." Legislators don't realize that emergency medicine groups lose money on Medicaid and self-pay patients and roughly break even on Medicare patients, and depend on the small minority of our patients with commercial insurance to stay open, pay our bills, and fund our huge charity mission. Capping out-of-network fees would remove whatever incentive insurers have to bargain with emergency medicine groups, allowing them to pay as little as they want for emergency medical care to both in- and out-of-network groups. This would destroy the medical safety net, unless government stepped in to keep EDs open. (For complete background on this issue, see the Academy's paper on the subject: https://www.aaem.org/UserFiles/BalanceBillingPaper.pdf.)

Some insurers have also recently explored the possibility of violating the prudent layperson standard, which forces them to pay for an ED visit based on the presenting complaint rather than the final diagnosis. Imagine if an insurer could refuse to pay you anything but a $28 fee for a medical screening exam when the patient's chest pain turned out to be anxiety rather than an MI – after four hours in the ED with two EKGs, two troponins, a chest x-ray, and lots of your time and expertise. That's what some insurers are pushing towards. The prudent layperson standard is written into federal regulations, and there is no chance it will be repealed, but enforcement is left up to the states. So again, most of the action on this will be at the state level. **There is no substitute for you being in regular contact with your state legislators, whether you call, email, or write.**

It isn't just your own welfare that requires you to be politically involved in your home state. Our profession, our specialty, and our patients depend on it. Lots of people with no medical training at all want to tell you how to do your job, or make it impossible for you to do your job in any way other than the one they choose. Patients needlessly suffer and even die when that is allowed to happen. Develop a relationship with your legislators and their staff. Educate them on how things affect our specialty, because emergency medicine is truly unique in all of medicine and you can't rely solely on your state medical society. Be involved with your chapter division of AAEM – or found one if your state doesn't have a chapter. And finally, stay in touch with me or a member of the GNA Committee in your state. If something comes up that we need to know about, the sooner we hear about it, the more we can do. ●

Get in touch with the GNAC at info@aaem.org.