



RESOLUTION: 25(20)

SUBMITTED BY: Arizona College of Emergency Physicians
Florida College of Emergency Physicians
Illinois College of Emergency Physicians
Indiana Chapter
Ohio Chapter
Pennsylvania College of Emergency Physicians
Texas College of Emergency Physicians
Virginia College of Emergency Physicians
Wisconsin Chapter
Air Medical Transport Section

SUBJECT: Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement & Optimal Patient Coverage

PURPOSE: 1) Create a task force and commission an independent study on the financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and withholding appropriate reimbursement against emergency physicians. 2) Engage with an independent healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of commercial health insurance and reimbursement policies on emergency care. 3) Advocate for higher standards and additional scrutiny of health insurer spending. 4) Work with other professional organizations, consumer advocacy groups, and the AMA to further understand the contribution of health insurers on the increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

FISCAL IMPACT: Budgeted task force and staff resources. Additional unbudgeted costs of \$10,000-15,000 for travel to attend meetings with similarly affected professional organizations, and/or convene an in-person task force meeting. Estimated \$50,000 in unbudgeted costs to contract with an independent healthcare economist to perform an economic analysis, excluding additional costs for required data sets. Actual cost for the economist would be determined by developing an RFP and receiving proposals based on the scope of work.

1 WHEREAS, The deliberate consolidation of healthcare insurers has reduced competition in the healthcare
2 insurance marketplace and has reduced healthcare insurance options for our patients; and
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4 WHEREAS, Healthcare insurers have reduced the actual healthcare insurance coverage of illness and injury
5 with high-deductible plans, increased patient cost-sharing and increased out-of-pocket expenses; and
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7 WHEREAS, Healthcare insurers have implemented many strategies to reduce physician reimbursement
8 including:

- 9 • termination or non-renewal of contracts to preemptively reduce compensation and decrease median in-
10 and out-of-network rates
- 11 • automatically down-coding or denying payment by using exempted diagnosis lists
- 12 • retrospectively denying higher-acuity emergency physician service payment by failing to acknowledge
13 the increased acuity of conditions presenting to the emergency department over the past decade
- 14 • bundling services (e.g., electrocardiogram interpretation) to avoid payment for cognitive services
- 15 • consistent cost shifting by The Employee Retirement Income Security Act (ERISA) plan administrators to
16 increase the costs to employers and employees
- 17 • disregarding the Prudent Layperson Standard (PLP) by retrospectively denying payment based on
18 discharge diagnosis; and
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20 WHEREAS, Health insurers are required to cover emergency services but have insufficient in-network
21 emergency physicians to provide these services and no requirement to contract with emergency physicians or to
22 negotiate in good faith to pay for EMTALA mandated care; and

23 WHEREAS, Healthcare insurers are reporting record profits including profit of \$18.4 billion for Centene, \$14
24 billion for United Health Group, \$5.1 billion for CIGNA, \$4.8 billion for Anthem and \$1 billion for CVS in 2019; and
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26 WHEREAS, During the COVID-19 pandemic when emergency physicians were focused on caring for
27 emergency patients, insurers were reporting record profits due to reduced payment for suspended elective non-
28 emergent procedures, while they continued to promote inequitable surprise billing legislation; and
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30 WHEREAS, The Affordable Care Act (ACA) requires health insurers to pay annual premium rebates when
31 the Medical Loss Ratio (MLR) for groups or health insurance policies issued in a state is below 85% for large
32 employer group policies and 80% for small employer group policies and individual policies; by failing to meet this
33 threshold, it is estimated the healthcare insurers will be required to rebate approximately \$2.7 billion in 2020 due to
34 failure to meet the MLR requirement; and
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36 WHEREAS, Health insurers have established large employer third-party administrators (TPAs), acquired
37 Pharmacy Benefit Management companies (PBMs) and medical practices, and that these entities accounted for more
38 profit than the core insurance business lines; and
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40 WHEREAS, Insurance companies by owning or influencing both medical practices, TPA's and PBM's they
41 are potentially "price-setting" and "self-referring" and these are not subject to MLR therefore they may be unilaterally
42 and arbitrarily increasing the costs of medical care with potentially little to negative effects on quality; therefore be it
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44 RESOLVED, That ACEP create a task force and commission an independent study on the extraordinary
45 financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and
46 withholding appropriate reimbursement against emergency physicians; and be it further
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48 RESOLVED, That ACEP engage an independent healthcare economist to analyze the reimbursement
49 challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of
50 commercial health insurance and reimbursement policies on emergency care; and be it further
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52 RESOLVED, That ACEP advocate for higher standards and additional scrutiny of health insurer spending,
53 including the Medical Loss Ratio (MLR) standards, to ensure more resources are dedicated to the patient health
54 services and not diverted for other business pursuits without clear benefit to their patient population; and be it further
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56 RESOLVED, That ACEP work with other similarly affected professional organizations, consumer advocacy
57 groups, and the American Medical Association (AMA) to further understand the contribution of health insurers on the
58 increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

Background

This resolution directs ACEP to: 1) Create a task force and commission an independent study on the financial influence health insurers have asserted over emergency physicians by leveraging EMTALA mandates and withholding appropriate reimbursement against emergency physicians. 2) Engage with an independent healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine and the effect of commercial health insurance and reimbursement policies on emergency care. 3) Advocate for higher standards and additional scrutiny of health insurer spending. 4) Work with other professional organizations, consumer advocacy groups, and the AMA to further understand the contribution of health insurers on the increased financial burden of patient access to emergency services and on the physician delivery of emergency care.

Recent Advocacy Efforts to Combat Unfair Insurer Practices

ACEP has continued to push back against burdensome and illegal insurer financial influence on reimbursement for emergency medicine as part of the strategic plan. These efforts included an ACEP-EDPMA Joint Task Force, formed in 2015, in part to combat unfair insurer practices against the specialty. While the task force is now defunct, ACEP and EDMPA have included a representative on each other's respective reimbursement and state and regulatory

committees to continue to push back against new and existing issues. ACEP and EDPMA have sent joint letters to Optum, United Health Care, Centene, and various Medicaid plans conveying concerns about their payment policies. Many ACEP chapters have sent letters to CMS and individual states regarding insurance denials and other specific reimbursement issues.

The continued termination or non-renewal of contracts, down-coding, or denial of payment via diagnosis lists, retrospective denial of higher-acuity emergency physician service payment, bundling services to avoid payment, consistent cost shifting by ERISA plans, and disregarding the Prudent Layperson Standard (PLP) by retrospectively denying payment based on discharge diagnosis will continue to be issues that ACEPs State Legislative and Regulatory Affairs, Public Affairs, and Reimbursement Departments budget time and staff resources for advocacy efforts.

ACEP also advocates for higher standards and scrutiny of insurer policies and spending through its representation at the American Medical Association (AMA), and along with other similarly affected specialties, advocates for policies that seek to restrict and/or prevent damaging insurer policies.

This resolution would take these efforts a step further by contracting with a respected healthcare economist to conduct an independent study to analyze challenges and adverse financial impacts to reimbursement from insurer policies.

Recent Advocacy Efforts to Uphold Legal Rights Established by EMTALA and Prudent Layperson (PLP)

Despite the longstanding legal precedence of protecting patients and physicians from unwarranted third-party payer denials established by EMTALA and PLP, significant numbers of denials continue to persist.

ACEP has continued to fight for the inclusion of the EMTALA provision in third-party payer policies, especially those from managed care plans, which have significantly increased their market share since EMTALA was mandated by law. Although PLP laws have largely eliminated the issue of prior authorization denials for emergency services, many third-party payers have continued to make after-the-fact decisions to deny payment for services resulting in loss of revenue for physicians and an unnecessary financial burden on patients.

ACEP also has continued tracking third-party payer denials and has successfully lobbied on behalf of members in states where policies were announced that would have led to a process of automatic denials. Letters have been sent to third-party payers that make up a large percentage of total market share in the U.S. with varying degrees of success. A lawsuit against BCBS in GA has been pending since 2018 and letters sent to UHC (multiple states) and Anthem BCBS (23 states) in the past year successfully defeating automatic denials and unfair down coding policies.

The College has continued to monitor and influence both the legislative and regulatory process related to EMTALA and PLP. We have successfully lobbied both Congress and the Centers for Medicare and Medicaid Services (CMS) on several issues of importance to emergency medicine, including removing criminal penalties against physicians, adding on-call requirements to the law, instituting whistleblower protections, and PRO review requirements. ACEP regulatory affairs staff have submitted formal comments to CMS and met with them on numerous occasions over the years to discuss the law, the regulations, and enforcement issues.

ACEP developed a toolkit in 2018 to reach out to third-party stakeholders to track and collect payment denials by Anthem Blue Cross Blue Shield in 23 states where the policy had taken effect. Billing companies, ED groups, and Academic Chairs in those states were asked to report any data or observations of denials that violate the prudent layperson standard.

Pursuing Strategies for Ensuring Fair Payment and Practice Sustainability

The current tactics for ensuring fair payment for services include:

- Engaging ACEP chapters, CMS, and the National Association of State Medicaid Officials in initiating and supporting efforts to minimize the impact of state Medicaid cuts on access to emergency care and to protect the prudent layperson standard.
- Collaborating with the AMA, state medical societies, and other medical organizations on payment and practice sustainability issues, including interaction with entities such as FAIR Health, NCOIL, NAIL, and PAI, as appropriate.

- Identifying payers that do not pay fairly and consider compliance disputes and legal actions through the most strategic available mechanisms, via the ACEP Coding & Nomenclature Advisory Committee, Reimbursement Committee, State Legislative/Regulatory Committee, and ACEP staff time devoted to advocacy efforts.

The proposed additional tactics of creating a task force and engaging a healthcare economist to analyze the reimbursement challenges and adverse financial impacts of the healthcare financing system on emergency medicine as well as the effect of commercial health insurance and reimbursement policies on emergency care are new tactics that could fit into the current ACEP Strategic Plan, although some of the associated expenses are unbudgeted.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care

Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted task force and staff resources. Additional unbudgeted costs of \$10,000-15,000 for travel to attend meetings with similarly affected professional organizations, and/or convene an in-person task force meeting. Estimated \$50,000 in unbudgeted costs to contract with an independent healthcare economist to perform an economic analysis, excluding additional costs for required data sets. Actual cost for the economist would be determined by developing an RFP and receiving proposals based on the scope of work.

Prior Council Action

Amended Resolution 38(19) Standards for Insurance Denials adopted. Directed ACEP to work with legislators to enact legislation that makes it illegal for a payor to engage in automatic denials; and that to deny a claim, a physician (i.e., MD or DO) who is board certified and remains clinically active in a field related to the claim, carefully review the denial, and attest to the cause of the denial with their signature attached to the documentation that shall be provided to the patient; and that patients have the legal right under EMTALA to seek emergency care and that their claims shall not be denied by payors; and that ACEP work towards getting an affirmation in writing from payors that they will adopt this as policy.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted. Directed ACEP to develop and enact strategies (including state and federal legislative solutions) to prevent payors from arbitrarily downcoding charts and work to develop and enact policy at the state and federal level that prevents payors from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal PLP laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Amended Resolution 26(14) Impact of High Deductible Insurance Plans adopted. Directed ACEP to convene a work group of subject matter experts to identify the impact that high deductible insurance plans have on patients seeking emergency care, emergency physicians, and emergency departments, and create a paper to inform stakeholders about such impact.

Resolution 38(05) Proper Payment Under Assignment of Benefits adopted. Directed ACEP to advocate for legislation and regulation to ensure that when authorized by the patient, a payer directly reimburses the provider for care.

Amended Resolution 34(02) Funding for EMTALA-Mandated Services adopted. Directed ACEP to collaborate with organizations whose members are affected by EMTALA to lobby Congress to fund EMTALA-mandated services not covered by current funding mechanisms; ask the AMA to make it a legislative priority to ensure that EMTALA-mandated physician services are funded; and provide a report to the 2003 Council on progress to date.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted. Directed ACEP to solicit member input to formulate EMTALA recommendations to CMS' regulatory advisory committee including physician on-call responsibilities, greater consistency of enforcement, and more effective involvement of peer review organizations.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. Reaffirmed that EDs are an essential part of the health care safety net for all populations, including foreign nationals, and in advocacy efforts ACEP recognizes uncompensated care for foreign nationals as one example of the many factors that threaten the health care safety net.

Resolution 26(01) Emergency Care as an Essential Public Service adopted. Directed ACEP to champion the principle that emergency care is an essential public service.

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA for emergency departments and provide a report at the 2001 Leadership/Legislative Issues Conference.

Resolution 15(99) Promotion of Health Care Insurance adopted. Directed ACEP develop a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured; make a long-term commitment to work with federal, state, and private agencies to resolve the problem; and provide a progress report at the 2000 Council meeting.

Amended Resolution 11(92) Payment for Mandated Services adopted. Directed that any government agency, legislative body, insurance carrier, third-party payer, or any other entity that mandates that a service or product be provided by emergency physicians or other providers, also mandate an adequate source of funding to ensure appropriate compensation for those services or products; and support legislation to ensure that any governmental agency, legislative body, insurance carrier, third party payer, or any other entity that mandates the provision of medical services or products, also provides for appropriate compensation for that service or product.

Prior Board Action

February 2020, approved prudent layperson model state legislation stipulating that “the health plan shall, in accordance with payment timeliness regulations, reimburse any undisputed amount while review of disputed portions of the claim is underway.”

January 2020, ACEP and EDPMA sent a letter to Optum conveying concerns about Optum's payment policies.

Amended Resolution 38(19) Standards for Insurance Denials adopted.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

January 16, 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25). July 17, 2018, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients.

February 2018, reaffirmed the policy statement “[Assignment of Benefits](#);” reaffirmed April 2012; originally approved April 2006.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

April 2017, approved the revised policy statement “[Fair Coverage When Services Are Mandated](#);” reaffirmed April 2011 and September 2005 with the title “Compensation When Services are Mandated;” originally approved September 1992.

April 2017, approved the revised policy statement “[Prior Authorization](#);” revised and approved October 1998; originally approved November 1987.

May 2016, ACEP [filed suit against the federal government](#). Following a federal government decision in favor of health insurance companies, the suit was filed against the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are “out of network” because of a medical emergency.

April 2016, approved the revised policy statement “[Fair Payment for Emergency Department Services](#);” originally approved April 2009.

April 2016, approved the revised policy statement “[Balance Billing](#);” revised and approved 2009 with the current title; reaffirmed October 2008; originally approved October 2002 titled “Prohibition of Balance Billing.”

Referred Resolution 28(15) Standards for Fair Payment of Emergency Physicians assigned to the ACEP/EDPMA Joint Task Force on Reimbursement.

Amended Resolution 26(14) Impact of High Deductible Insurance Plans adopted.

April 2014, revised and approved the policy statement “[Third-Party Payers and Emergency Medical Care](#);” revised and approved June 2007, July 2000, and January 1999; approved March 1993 with title “Managed Health Care Plans and Emergency Care;” originally approved September 1987.

Resolution 38(05) Proper Payment Under Assignment of Benefits adopted.

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Substitute Resolution 29(01) Funding of Emergency Care for Foreign Nationals adopted.

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

Amended Substitute Resolution 15(00) EMTALA adopted. A report was distributed at the 2001 Leadership/Legislative Issues Conference.

Resolution 15(99) Promotion of Health Care Insurance adopted. ACEP’s Task Force on Health Care and the Uninsured developed six principles to be used as a framework for expanding health care coverage to all. In 2000, ACEP hosted the National Congress on Preserving America’s Health Care Safety Net in Washington, DC. This initiative called for a national debate on the issue and for building a national consensus among leaders in business, consumer and advocacy groups, public policy, health care, and medicine to make incremental changes to expand health care access. ACEP also joined six other medical specialties in calling on Members of Congress and presidential candidates to begin a serious debate over the health care funding crisis confronting the nation. Coverage of the uninsured will reduce the financial pressures on EDs of EMTALA compliance.

June 1999 approved the revised policy statement, "Compensation When Services are Mandated."

Amended Resolution 11(92) Payment for Mandated Services adopted.

Background Information Prepared by: Adam Krushinskie, MPA
Reimbursement Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director