

**Emergency Physicians’ Response to *JAMA*’s Fundamentally-flawed
“Assessment of Out-of-Network Billing for Privately Insured Patients
Receiving Care in In-Network Hospitals”**

Executive Summary

The over-simplified methodology used in the paper “Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals” recently published in *JAMA Internal Medicine*, is fundamentally flawed and does not take into account regional differences in the health care market.

The paper uses the difference between the amount of the physician charge in each out-of-network claim included in the study’s sample set, and a *national* mean for what the insurer would pay for a given service provided in-network (i.e. the allowed amount), to determine an estimated increase in the incidence of, and potential financial patient liability for, out-of-network bills for emergency care.

However, allowed amounts paid by insurers for emergency visits coded as moderate have significant variation both within and between states—as much as three- to four-fold. In addition, since in-network allowed amounts from insurers are generally lower than out-of-network payments, using in-network payments to estimate the balance for an out-of-network claim will only further overstate these findings.

These then already overstated findings are further distorted, since the paper’s estimated incidence of 39.1 percent of out-of-network emergency visits quietly includes those from medical transport—not just from physicians—which drastically inflates the overall number, since (according to other studies’ estimates) over half of ambulance transports are out-of-network. No individualized numbers to split out these ambulance transports are even provided.

Perhaps in a bid for headlines, the paper also conflates a claim submitted to the insurer by the physician with a balance bill sent to the patient, further exaggerating its already unfounded estimates of the frequency of balance billing of emergency patients. If the database studied is accurately described in the paper, it would be impossible to know from any of the analyzed claims if the patient actually received a balance bill from the physician.

The paper examined only 13.58 million emergency department visit claims across the nation for 2010 to 2016, which represents only 1.4 percent of the CDC’s estimated 951.6 million ED visits nationwide for the same seven-year period. Furthermore, this study period coincides with three major changes in health care, including the passage and later implementation of the Affordable Care Act (ACA), and intentional narrowing of insurer networks, which are significant confounding variables that likely distort any analysis of access and insurance coverage.

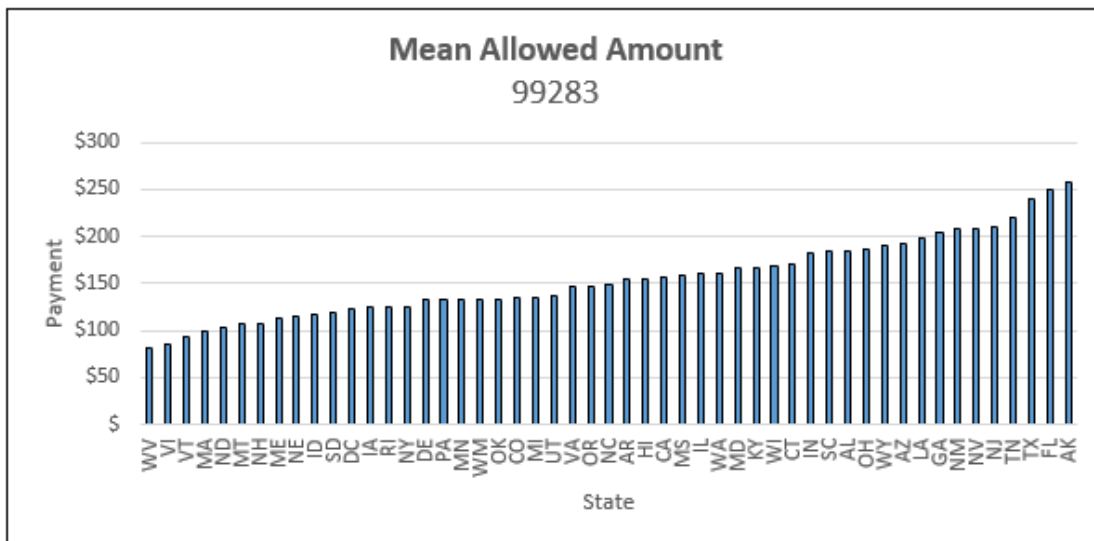
Introduction

Emergency physicians are the only safety net for many in our country, including vulnerable Medicare, Medicaid, pediatric, and many under- and un-insured patients. As Congress continues its efforts to advance legislation to protect patients from surprise medical bills, it is therefore critical that these important policy decisions are being made on accurate and reliable research. Patients should be taken out of the middle and protected from balance bills when emergency care is out-of-network, but if some of the proposals currently being considered at the federal level were put in place, it will be exceedingly difficult for emergency departments—especially those in rural or urban underserved areas—to keep the doors open 24 hours a day, 365 days a year. The American College of Emergency Physicians (ACEP) is therefore especially concerned that flawed research on surprise billing recently published in *JAMA Internal Medicine* has received such widespread attention from both the media and policymakers alike.

The Paper's Key Findings Rest on a Flawed Methodology

Much of the paper's findings and conclusions are derived from a fundamentally flawed presumption. It concludes that over the seven-year period of the paper (2010-2016), the incidence of out-of-network billing for emergency department (ED) visits increased from 32.3 percent to 42.8 percent, and the potential financial liability for patients receiving out-of-network bills from an ED visit increased from \$220 to \$628. Yet the authors acknowledge these figures were derived by simply calculating the difference between the amount of the physician charge in each out-of-network claim included in the paper, and a *national* mean for what the insurer would pay for a given service provided in-network (i.e. the allowed amount).

This enormous generalization should call into question the validity of the entire paper's findings, given the significant amount of geographic variability in insurer allowed amounts not only from state to state, but even *within* a state. To wit, the FAIR Health allowed amounts database benchmarks the in-network amounts insurers will pay for a service in a given geographical area. For an emergency visit of moderate severity (billed as CPT code 99283), allowed amounts just within New York State in 2018 ranged from as low as \$47 in a particular "geozip" (generally the first three digits of a zip code), to as high as \$184—an almost four-fold difference. Similar variation exists from state to state as well. For example, the mean allowed amount for a 99283-coded moderate emergency visit in West Virginia is \$81, while the mean allowed amount for that same claim in Florida is over three times as much at \$250.



Further, it is unclear why the paper's authors conclude that increases in the estimated potential financial patient liability from \$220 to \$628 during the paper period came from increases in the provider charge, rather than decreases in the insurer payment. The paper methodology only calculated the difference between the physician charge and the national mean insurer allowed amount and provides no data that definitively shows the source of the increase in this difference was the provider rather than the insurer.

From 2015 to 2017, the 80th percentile of physician charges for 99283 in New York State rose only slightly from \$398 to \$410 (well below inflation increases as measured by the Consumer Price Index's Medical Care category). Meanwhile, during the paper's seven-year time period insurers continued to decrease payments and shift those costs to policyholders in the form of higher deductibles and patient cost-sharing. The average deductible for those with employer-sponsored coverage actually *doubled* during the paper's seven year-period, rising from

\$646 to \$1,221¹. Yet the paper leaves out patient cost-sharing responsibilities, while in reality insurance dynamics have been impacted by multiple variables, far more than just the two variables examined under the paper's simplistic construct.

With regard to estimating the incidence of out-of-network billing for emergency care, the paper also combined emergency visits with an out-of-network bill from a physician, with those emergency visits with an out-of-network bill from a medical transport service. A 2016 paper in Health Affairs found that over half of ambulance transports were out-of-network²; it can therefore be assumed that a significant portion of the JAMA authors' estimated 39.1 percent of ED visits resulting in an out-of-network bill actually comes from medical transport being included in the paper sample. It is disappointing that the authors did not split out the incidence of out-of-network emergency bills that resulted from air or ground ambulance transportation from those that were from physicians.

The Paper Conflates a Provider Claim Sent to the Insurer with a Bill Sent to the Patient

The paper's findings of increases in the incidence of out-of-network bills sent to patients following ED visits from 2010 to 2016 are also derived using a flawed methodology. The paper notes:

“For each claim, the database reports information such as service dates...and whether the claim was paid as in-network or out-of-network. In addition, each claim reports financial variables including the amount charged by the clinician and a standardized cost, which broadly represents the national mean amount insurance companies would pay an in-network clinician or medical transport service (ie, ambulance) for the service.”

Later the authors' note that they analyzed (emphasis added) “whether **the patient received** any out-of-network bill during the inpatient admission or ED visit, which was directly reported on the claim”. This contradicts the description of the database and claims from which the paper's findings are derived. A claim submitted to the insurer (which customarily includes the physician's charge) is very different from the *patient* receiving a bill from the physician, and the two should not be conflated. Yet the paper regularly switches from one to the other with no distinction or clarification, thereby obfuscating the true findings.

In short, if the above database description is accurate, **it is impossible to know in any of the analyzed claims if the patient received a balance bill from the physician at all**. From the authors' own description, the database only tracks whether a claim for a physician was paid by the insurer as out-of-network. It does *not* track the amount paid by the insurer, and instead only provides a national mean *in-network* allowed amount. The authors seem to have concluded that if the national mean in-network allowed amount for that service was less than the physician charge on the claim, then the patient received a balance bill. We have already showed the significant range of in-network allowed amounts in different geographic areas, but there is an additional important distinction here. The analyzed claims were paid as *out-of-network* by the insurer, yet the comparative national mean payment from the database is an *in-network* allowed amount. Insurers generally pay a lower rate for in-network than out-of-network care, since providers accept this lower rate in exchange for the efficiencies, predictability, and convenience that being in-network provides. Therefore, this apples-to-oranges comparison only serves to further inflate the paper's already unfounded estimated incidence of balance bills.

¹ Increases in cost-sharing payments continue to outpace wage growth. Gary Claxton, Larry Levitt, Matthew Rae, Bradley Sawyer; Kaiser Family Foundation. Peterson-Kaiser Health System Tracker. June, 2018.

² One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills. Garmon, Christopher & Chartock, Benjamin. (2016). Health Affairs. 36. 10.1377/hlthaff.2016.0970.

Paper Findings Confounded by Concurrent Major Changes in Health Care

Even if the paper *had* been able to accurately track an increase in out-of-network balance bills from 2010 to 2016, the time-period coincides with three significant changes in health care that would likely distort any analysis of access and insurance coverage:

1. Significant rulemaking immediately followed passage of the Affordable Care Act (ACA) in 2010, with a June 2010 interim final rule³ that opened the door for insurers to manipulate and reduce their payments to physicians who provide out-of-network emergency care.
2. Almost concurrently, to dodge the requirements of a 2009 settlement of a suit brought by the State of New York against a number of major insurers, many plans were turning to alternative methodologies for determining out of network payments⁴. Some plans began to reduce these payments by linking them to Medicare calculation—which the Centers for Medicare and Medicaid Services (CMS) has acknowledged do not keep up with practice costs—while others used their own favorable interpretation of the new standards from the ACA rule to justify greatly reduced provider payments.

As a result, instead of payments that covered most out-of-network emergency care claims in full, plans began to make greatly reduced payments and transferred the liability for these claims on to the backs of their policyholders. In 2013, ACEP analyzed the claims database of one of the largest national emergency physician billing companies. The claims represented approximately 7 percent of all emergency physician claims submitted nationally. The analysis focused on claims submitted to two national health plans in 2013, which totaled over 200,000. It found that both plans had substantially lowered the benefits to their enrollees for out-of-network emergency physician services during 2013—payments from one plan decreased by an average of \$61, while payments from the other decreased by an average of \$325.

3. The last confounding variable began in 2014, when full implementation of the Affordable Care Act went into effect and health plans were offered on the individual market. Due to the law's strict plan design requirements and cost limitations for such plans, switching to a narrow-network design remained as one of the few ways left for health insurers to manage costs and maintain profitability. In 2013, 20 percent of plans in the individual market had narrow networks. In 2014, that number increased to 41 percent of products offered on the exchanges having narrow networks⁵. A separate paper shows the further narrowing of plans continued, estimating an increase from 48 percent of exchange plans in 2014 being considered narrow, to 68 percent in 2017⁶.

Narrow networks are even more of an issue when it comes to care provided by other hospital-based providers, and in particular emergency care⁷. Under the Emergency Medical Treatment and Labor Act (EMTALA), insurance companies are guaranteed their policyholders are able to access emergency care, and therefore have no need to have adequate numbers of emergency physicians in their networks. The insurers are further incentivized to keep their networks narrow since if a policyholder's emergency care

³ 75 Fed. Reg. 37,188, 37,194 (June 28, 2010).

⁴ “[Insurers Alter Cost Formula, and Patients Pay More](#)”. Nina Bernstein. New York Times. April 23, 2012.

⁵ Hospital networks: Updated national view of configurations on the exchanges. McKinsey Center for US Health System Reform. Noam Bauman, Erica Coe, Jessica Ogden, Ashish Parikh. June, 2014.

⁶ The High Cost of Healthcare: Patients See Greater Cost-Shifting and Reduced Coverage in Exchange Markets 2014-2018. Physicians for Fair Coverage. Research by Avalere, July, 2018.

⁷ Trends in Physician Networks in the Marketplace in 2016: Prevalence of narrow networks and comparisons with 2014. Daniel Polsky, Yuehan Zhang, Laura Yasaitis, and Janet Weiner. December, 2016. <http://ldi.upenn.edu/brief/trends-physician-networks-marketplace-2016>

happens to be out-of-network, the patient's deductible is likely significantly higher, which then shifts the majority—if not the entirety—of the cost of the emergency encounter to the patient, rather than the insurer.

Therefore, were we to have an actual, verifiable accounting of the number of out-of-network emergency claims, it would not be surprising to see increases.

Conclusion

In summary, it is disappointing to see such an inaccurate and biased accounting of trends in out-of-network claims in this paper. In addition to the omissions we noted of important variables, much of the surrounding verbiage in the paper further skews the findings by presenting insurers as being at the mercy of provider actions without any agency of their own. The authors note, “some physicians are not hospital employees and make decisions separate from the hospitals about participating in insurance”. This ignores entirely the insurer role in the contracting process, placing all decisions and blame solely on the provider. The sentence could just as easily be reframed as “some physicians are not hospital employees, and therefore are treated separately by insurers when such plans are developing their provider networks.”

This seeming bias is perpetuated in the paper's accompanying editorial from *JAMA Internal Medicine's* editor which states “A common reason [for surprise medical bills] is that certain physicians, such as an anesthesiologist, an emergency department physician, a pathologist, or a radiologist, may not participate in a health insurer's network and bill the patient directly.” This over simplified statement ignores that physicians may not have been given an opportunity to participate in the network. For example, a 2014 Texas Medical Association survey reports that among physicians who approached an insurer in an attempt to join its network, 29 percent received no response at all⁸.

One place where we do agree with the paper is where it notes, “Policies that limit the ability of physicians and medical transport services to balance bill patients – for example, by shifting some portion of the patient's responsibility to insurers – offer stronger protection.” While current law requires patient cost-sharing to be the same for in- or out-of-network emergency care, it defines cost-sharing in that provision (Public Health Service Act Section 2719A) as only the copay and coinsurance—not the deductible. Patients in an emergency don't have time to verify if their emergency provider is in or out-of-network, so they shouldn't be punished financially if they happen to be seen by an out-of-network provider. ACEP has repeatedly advocated in congressional discussions for the equal cost-sharing provision in Section 2719A to be extended to deductibles^{9,10,11}. This would incentivize insurers to negotiate fairly to bring more emergency physicians into their networks.

⁸ [Texas Medical Association 2014 Survey Research Findings](#)

⁹ [ACEP Framework for Addressing Out-of-network Emergency Care](#)

¹⁰ [Testimony of ACEP President Vidor Friedman, MD, FACEP](#) in June 10 Energy & Commerce Health Subcommittee hearing, “No More Surprises: Protecting Patients from Surprise Medical Bills”

¹¹ [ACEP Response to Energy & Commerce Committee](#) Request for Comment on Draft Legislation on Surprise Billing, May 28, 2019.