

## Coerced Contracting is Not a Reasonable Solution to Balance Billing

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Regarding the article on access to in-network emergency physicians, the authors conclude that a solution to the lack of access to in-network emergency physicians at many hospitals may be to require plans to contract with these physicians at hospitals that are in-network with the plan (if I understand their approach correctly). Though this mandate might be helpful in some cases, it is just as likely to increase the incidence of coercive contracting, where the plan puts pressure on a hospital in their network to force the emergency physician group at the hospital to accept deeply discounted rates from the plan, or be replaced by another group that will. A better solution would be for plans to be required to pay out-of-network emergency physicians (and on-call specialists) based on a benefit for out-of-network services that is a commercial market-based representation of the reasonable value of these services. Some percentile of usual and customary charges, using a database like the one established by FAIR Health, would provide such a reasonable value standard, while limiting outlier charges that are excessive and unreasonable. This approach is predicated on the idea that most physicians' charges are reasonable, are designed to address practice costs and overhead, allow these physicians to meet their

EMTALA mission to provide care to all, regardless of insurance status or ability to pay, and are subject to the pressures of the market for these services. This in turn would encourage plans to negotiate fairly with emergency physician groups, and not just take advantage of the EMTALA obligation or coercive contracting. It would also eliminate the need for so-called surprise balance billing.

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## In reply to: Coerced Contracting is Not a Reasonable Solution to Balance Billing

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We appreciate the letter to the editor and are pleased to respond to comments regarding our article on in-network access to emergency physicians. In our article, we highlighted that the present methods used by CMS to determine network adequacy for physicians in most medical specialties are not applied to emergency medicine. Rather, CMS enforces minimum payment thresholds for out-of-network emergency medical care. That threshold, known as the “greatest of three,” is the greatest of the following: the plan’s median payment amount for in-network providers, a payment based on the usual methods the plan uses to determine payments for other out-of-network services, or the amount that Medicare would pay for those services. Following this model (and the data that we presented regarding in-network physicians), we concluded that the present regulatory structure disincentivizes the formation of adequate emergency physician networks and therein incentivizes the practice of balance billing as physicians seek to compensate for the out-of-network care they provide.

We proposed that - in lieu of applying network adequacy standards to emergency physicians – and rather than defaulting to the present out-of-network payment thresholds, all emergency physicians should be paid an in-network rate negotiated with insurers. The letter to the editor suggests that it would be better to use a standard threshold of usual, customary, and reasonable (UCR) charges set by the market. However, we identify several issues with this proposal.

UCR charges are typically the highest of the “greatest of three,” because they are the product of both (lower) in-network and (higher) out-of-network rates. As such, the adoption of a system defaulting to UCR charges would reasonably disincentivize emergency physicians from entering networks in favor of the higher out-of-network UCR charge. Furthermore, in defaulting to UCR charges, the practice of balance billing would become unnecessary, eliminating one of the incentives of coercive contracting.

However, defaulting to UCR charges would also change the incentives for emergency physicians to enter networks in the first place, as out-of-network emergency physicians would receive a higher rate by default. This may in turn result in a snowball effect wherein more physicians remain out of network, driving up UCR charges. It is foreseeable that such a scenario would incentivize carriers to actually increase the practice of coercive contracting so as to avoid paying higher UCR charges. That could, in turn, lead to an ultimate loss in physician reimbursements - even below present in-network rates.

Another issue with UCR charges is the present lack of transparency in their calculation. As recently as 2010, UnitedHealthcare subsidiary Ingenix was found guilty of manipulating data to underpay physicians, resulting in a fine of \$300 million and the creation of a third-party, nonprofit database for charge data called FAIR health. In May 2016, after our article was published, ACEP filed a lawsuit against HHS for a similar claim, asserting that the “greatest of three” defaults lack transparency. It is unclear what will come of the suit, but the issues with UCR charges remain.

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