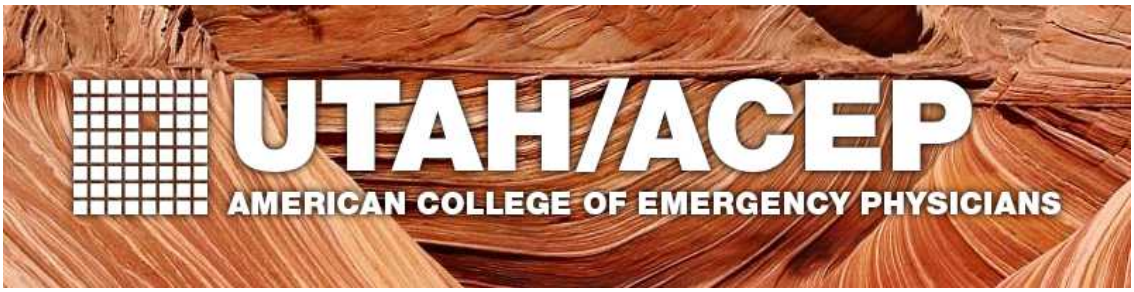
A Newsletter for the Members of the Utah Chapter

Winter 2017



John Dayton, MD, FACEP
President

Paige DeMille
Executive Secretary

Todd Yeates, DO
Newsletter Editor

Chapter Contact
Phone: 801.747.3500
Fax: 801.747.3501

From the President
John Dayton, MD, FACEP

One of the major issues this legislative session is Balanced Billing. Representative Jim Dunnigan, an insurance agency owner, has proposed legislation to ban this practice. Although balanced billing is not an ideal solution, it is an uncommon practice in Utah EDs. A ban on

balanced billing would negatively affect patient access, specialty coverage, and reimbursement for Utah's Emergency Departments.

What is balanced billing?

This is the practice of a hospital or physician billing a patient for the outstanding balance after the insurance company submits its portion of the bill
Out-of-network physicians are not bound by in-network agreements and are able to bill patients for the entire remaining balance
This occurs most often in two types of situations: 1) when a patient receives care they believed was in-network, but wasn't, and 2) when an insurance company pays less for health care than the patient expected

Why are patients upset?

The **Affordable Care Act (ACA)** has led to both an increase in high deductible plans and narrowing coverage networks, causing many providers to become "out-of-network". As a result, balanced billing has increased dramatically since 2011
Per past ACEP President Jay Kaplan, "Americans who have chosen health plans based on affordable premiums have found themselves unable to afford relatively high deductibles."
According to a Kaiser Family Foundation study, because of high out-of-pocket costs, 43% of patients skipped physician-recommended tests or treatment and 41% did not fill prescriptions.
Delay of care often results in a visit to the Emergency Department
Additionally, 20% of patients report problems paying medical bills due to out-of-network care or unexpected claim denials

Why is this important to Emergency Physicians?

Because emergency care is mandated by the **Emergency Medical Treatment and Labor Act (EMTALA)**, and due to the nature of emergency care, emergency physicians do not choose their patients or discuss coverage options in emergent situations. We provide emergency care whenever it is needed.
Emergency Physicians provide an average of $150,000 a year in uncompensated care. This is up to ten times higher than any other specialty.
A ban on balanced billing would allow insurers to arbitrarily set reimbursement rates for care that we are legally required to provide
In addition to affecting Emergency Physicians, a ban on balanced billing would also limit specialty coverage taking call for Emergency Departments

What does ideal legislation look like?

Because emergency care is mandated by EMTALA, it should be exempt from any proposed ban on balanced billing

Any effort to restrict balanced billing should be tied to a transparent, enforceable and acceptable **Minimum Benefits Standard (MBS)**. One example of this is the FAIR Health database which is unbiased and recommends regional reimbursement rates.

ACEP recognizes Connecticut's new state law as model legislation to address this concern. It sets the FAIR Health as the MBS, and insures **Alternative Resolution Disputes (ARDs)**are not needed

If ARDs are used, they should not involve the patient, but should be resolved between the physician and the insurer.

Medicare and Medicaid are NOT appropriate benchmarks for determining out-of-network payment. These rates are politically derived to cover a specific group of patients according to budgetary and regulatory constraints, and should not be applied to the context of commercial insurance.

Has legislation been proposed in Utah to ban balanced billing?

Rep. Jim Dunnigan's (District 39 - Taylorsville) is an insurance agency owner and is proposing to ban all balanced billing (H.B. 336). **Rep. Dixon Pitcher's** (District 10 – Ogden) has also proposed banning balanced billing, but is recommending more reasonable reimbursement rates for out-of-network care than Rep. Dunnigan. Not surprisingly, the insurance industry does not like Rep. Pitcher's bill.

I met with Rep. Dunnigan in January to discuss his legislation and the unique impact it would have on Emergency Medicine. He acknowledges most balanced billing from emergency care is related to specialty consults and not from Emergency Physicians. However, he is not interested in excluding Emergency Care from his legislation.

He proposed that reimbursement for out-of-network bills should be the covered according to a fraction of the in-network rates or a according to a local standard rate from FAIR Health. He notes this would be preferable to using a Medicare rate.

Although he says he is open to using an independent database like FAIR Health, he is concerned that it does not have complete enough records for Utah to set regional standards for billing rates. However, Michelle McOmber, who represents the UMA notes that FAIR Health has access to almost 50% of Utah reimbursement data.

We would like to protect our patients from unreasonable bills, but we also don't want caps or limits assigned to billing, as this would impede our ability both to collect reasonable reimbursement and negotiate future reimbursement rates with insurance companies.

How can I get involved?

Call or email the Representative and Senator that represent where you live and where you work.
Find out who represents your legislative district **here**.

Sources and Related Information:

ACEP Clinical Practice and Management: Balanced Billing. Revised and approved by the ACEP Board of Directors in April, 2016
Murphy, Brooke. 5 More Thoughts on Balanced Billing from the President of ACEP. Beckers Hospital Review. 2/24/2016
Murphy, Brooke. Letter to the editor: President of ACEP responds to '20 things to know about balanced billing.' *Beckers Hospital Review*. 2/24/16
Jaquis, William. ACEP, EDPMA Address Out-of-Network and Balanced Billing Issues. ACEPNow. 5/16/16
Yore, Liam. Emergency Physicians Should Work on Solutions to Balanced Billing Issues. ACEPNow. 11/17/15.

Legislative Update
Jim Antinori, MD

The Utah Legislature began its 2017 session on January 23. As I write this (January 24), multiple bills have been submitted that could potentially impact our specialty and our patients. There are several bills being proposed this session with implications for medicine in general and emergency medicine in particular. The Utah Medical Association's Legislative Committee, which I am honored to chair, will consider all medically-related proposed legislation and recommend a position for the Medical Association to take on each bill. The UMA can choose to support, oppose or take no position on any bill, and lobby accordingly.

Multiple bills of interest to emergency physicians will be debated. Without going into specifics at this time, proposed legislation includes bills on medicinal cannabis; limits on opioid prescribing; limits on the administration of "deep sedation" and "moderate sedation" by non-anesthesiologists or CRNA's; and others.

From the standpoint of emergency medicine, the most important bills to be considered in 2017 deal with the issue of balanced billing patients who are seen "out of network". Some bills have proposed that physicians be banned from balance billing any patient for out-of-network services. A variety of mandatory reimbursement mechanisms for physicians have been

proposed, and will be debated.

We know that unreasonably narrow provider networks and the high deductible/copayment plans that insurance companies are promoting to the public are major factors in this issue. Unfortunately, the legislature may not yet understand those factors. The fact that a ban on balance billing would effectively eliminate the ability of emergency physicians and other EMTALA-obligated providers to effectively negotiate with insurance companies has also not been addressed.

Some legislators believe that balance billing is common, and that large numbers of patients are being charged outrageous fees by physicians. Available data suggest otherwise, but a few anecdotal cases with egregious out-of-network billing examples have been presented to "prove" that the problem is rampant. The Utah Hospital Association and IHC, as yet, have not stated their official positions, although the proposal will impact them as well.

Utah ACEP and the Utah Medical Association, along with anesthesia and other specialty groups, will be closely watching this and other proposed legislation, and trying to make sure that the outcome is fair for all parties. Utah ACEP members may be called upon to contact and educate their state representatives and/or senators on this and other matters. Please be willing to do so, if asked. It's really important.

Please feel free to contact me if you have any questions about this or any other proposed legislation.

Upcoming Educational Opportunities

Upcoming University of Utah Emergency Medicine Grand Rounds Speakers
We are very excited about our upcoming Grand Rounds speakers, and would like to invite everyone to come see some great presentations and learn from nationally recognized leaders in our field.

February 15 8-10 am, – Dr. Richard Levitan

Eccles Institute of Human Genetics Auditorium, 1st Floor

Dr. Levitan is an internationally recognized airway expert whose airway management courses

are offered throughout the U.S. as well as many other countries. He is also the inventor of a number of airway devices, and he will be speaking
on the following topics:

1. Save a Life – Cut the Neck
2. Incrementalization – The Key to Doing Well & Being Well in EM
3. Challenging Airway? Don't Just Try Something Different - - Do Something Smart!

April 12 11am-1pm, - Dr. Mark Rosenberg and Dr. Adelaide Viguri

Annette Poulson Cumming College of Nursing Auditorium, 2nd Floor, Room 2300

Dr. Rosenberg and Dr. Viguri are emergency physicians from the St. Joseph's Healthcare System in Paterson, NJ and are nationally recognized leaders in the initiative to stem the use of opiates whenever possible in the ED. They will be speaking about our current nationwide opioid crisis, and the ALTO program (Alternatives to Opiates) they are using in their own ED.

Use the **link** to a searchable University of Utah Campus Map to facilitate directions.

Please contact **Christine Carlson** (EM Residency Program Manager) if you have any questions about these presentations.

UCEP Chapter Recap

What has the Utah College of Emergency Physicians (UCEP) done for Utah physicians this past year?

Lobbied Utah's Senators and Representatives on Capitol Hill in Washington, D.C. to advocate for decreased psychiatric boarding times, better liability protection for Emergency Physicians, and abolishing the Sustainable Growth Rate (SGR) reimbursement system.
Fought against the proposed exorbitant increases in licensing fees for Utah emergency physicians
Lobbied against making balanced billing illegal in Utah (i.e., protecting patient access to care and Emergency Physician compensation)
Sponsored a full day of CME events including a comprehensive LLSA review, lectures by the National ACEP President Jay Kaplan, as well as presentations on hot topics in emergency medicine, and ultrasound skills sessions

Represented Utah and advocated for issues important to Utah Emergency Physicians at the annual national ACEP Council in Las Vegas, NV

We need **YOU!** Join us in protecting our specialty and advocating for our patients. Go to our **Chapter web page** or e-mail **Paige De Mille** to find out how to get involved.

Also, be sure to contact your **state representatives** about issues important to you and our patients! You **CAN** make a difference.

Clinical News

CT Can Indicate Mortality Risk in Elderly with Trauma

NEW YORK (Reuters Health) – Opportunistic CT screening for osteopenia and sarcopenia in older adults with traumatic injury can provide insight into frailty and one-year mortality, according to Seattle-based researchers.

Read More

HCV Infections Less Prevalent than Previously Estimated

NEW YORK (Reuters Health) – The global estimate of hepatitis C virus infection (HCV) is lower

than previously thought, making World Health Organization targets for reducing infections and HCV-related deaths more attainable, researchers suggest.
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Free CME for Reading Annals of Emergency Medicine's Practice and Clinical Updates
Earn CME credit while reading the number-one journal in our specialty. Each month, a new Annals of…
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Diversity and Inclusion: Our Chapters, Our Duty
Ryan P. Adame, MPA, CAE
Deputy Executive Director, California ACEP
Chair, ACEP Chapter Executives Forum
Member, ACEP Diversity & Inclusion Task Force

Diversity. Inclusion. Worthy goals or buzzwords? What do they mean to you? What is your reaction when you hear them being discussed? How much have you reflected on the diversity of your leadership, or the opportunities for inclusion in your organization? I hope you will take a moment to consider your answers to these questions, as well as to whatever feelings or emotions you experienced when you read "diversity" and "inclusion" because acknowledging our successes and shortcomings is, I believe, the first step to building organizations that better serve our physicians and, in turn, their patients.

Here are some statistics to consider about ACEP membership: women comprise 26% of total membership, 28% of committee membership, are 26% of committee chairs, and 27% of the Council. In senior leadership, women represent just 12.5% of the ACEP Board of Directors, and just 19% of Chapter presidents are female. Approximately 1% of ACEP members are African-American and another 1.5% are Hispanic. While this is just a sample of membership attributes, there are many, many other aspects of diversity to consider: other ethnic groups to be sure, but also LGBT members, religious cross-sections, as well as generational considerations.

Why does this matter? To me, this matters because we have the opportunity and the duty to help build more diverse organizations that are reflective of the memberships we serve. Beyond diversity, inclusion matters because without meaningful participation by a diverse group of people, diversity can be reduced to a demographic check-box exercise. Our task, in my view, is to assist and, when necessary, lead our physician members in meaningfully integrating voices

and perspectives that are as different as the millions of patients they treat every year.

As the staff leaders within our family of organizations, we have unique access to and influence over our programs, our communications, and, most importantly, our leadership. I urge you to examine what your Chapter currently does to ensure better diversity and inclusion in leadership. Maybe right now the answer to that is “nothing.” We all have to start somewhere. Perhaps that means making inroads in your educational conference faculty’s diversity. Perhaps it means that you have to cultivate younger leaders differently, or help connect members from underrepresented groups with current leadership. Many Chapters already have resident members of their Boards of Directors but if you do not, there is another opportunity. Check that your meetings and conferences do not conflict with major religious holidays. Consider programming aimed at unconscious bias and/or health care disparity.

There are many avenues by which our family of organizations – ACEP, Chapters, and EMRA – can build better, more diverse, more inclusive organizations for our members. But first, like our members do each and every day, we have to triage. We have to look honestly and soberly at our organizations as they are today and ask ourselves how we can make them more diverse, more inclusive for the members of today and tomorrow.

New Congress, New Administration, New Challenges

Now is not the time to sit on the sidelines. Wondering how can you influence health care policy on the national level?

Join the **ACEP 911 Grassroots Legislative Network** today to help emergency medicine convey our principles and priorities to legislators in Washington DC and their home districts.

Already a member of the Network? Take your advocacy to the next level. Host an emergency department visit for your legislator or invite them to meet with a group of local emergency physicians from your chapter.

Newly elected and veteran legislators are hiring key staff, getting up to speed on important issues, and setting priorities for the new Congress. Now is the perfect time to reach out on the local level to educate the member about the specialty and offer to serve as a local resource on issues relating to the delivery of health care.

Go to the **ACEP Grassroots Advocacy Center** for detailed information on how to join the program and start engaging with legislators today!

Emergency Department to Hospital Admission and Discharge, Developed and Provided by ACEP, SHM and Our Educational Partner

EARN FREE CME - Heart Failure Management: From the Emergency Department to Hospital Admission and Discharge

Emergency medicine clinicians and hospitalists have a unique, collaborative relationship in the continuum of care of acute heart failure (AHF) treatment- providing optimal patient care from first point of access through hospitalization to discharge.

Click **here** to take this free CME course and get up-to-date, evidence-based information on the clinical presentation of AHF, the importance of an accurate and timely diagnosis, and more!

This program developed and presented by ACEP in collaboration with Haymarket and is made possible through an educational grant from Novartis.

Utah Chapter ACEP, 310 E 4500 South #500,
Salt Lake City, UT 84107