

February 22, 2019

The Honorable Bill Cassidy, M.D.
520 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Michael Bennet
261 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Lisa Murkowski
522 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Tom Carper
513 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Todd Young
400 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Maggie Hassan
330 Hart Senate Office Building
Washington, D.C. 20510

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Dear Senators Cassidy, Murkowski, Young, Bennet, Carper, and Hassan:

On behalf of the American College of Emergency Physicians (ACEP) and our 38,000 members, thank you for the opportunity to share additional data and more complete feedback regarding your effort to lower health care costs and improve price transparency for patients.

We appreciate the open process that your workgroup has taken to date, including the request for input in March to which [ACEP responded](#), the cross-sector roundtables in July and November that we were invited to participate in, and the request for input in October to which ACEP [also responded](#).

We strongly agree that more must be done to protect patients and their families from unexpected high medical bills and provide greater stability and transparency in these encounters. As we look towards a federal solution to addressing surprise bills, we believe three important principles should guide how we approach out-of-network emergency care:

- Protect patients by truly taking them out of the middle and holding them harmless
- Level the playing field and encourage fair and reasonable contracting for in-network services
- Recognize the unique nature of emergency care

That is why last month ACEP released a proactive [Framework for Protecting Patients When Emergency Care is Out-of-Network](#) that lays out a proposed federal approach for addressing surprise billing for emergency patients.

We appreciate the opportunity to now share further comments with your Workgroup that more specifically address the feedback and additional data you seek. We have attempted to provide as much information and data as possible. However, as a national specialty society and not a business entity, we do not have claims, billing, or coverage data. We are therefore providing what we have been able to collect from a variety of sources; we note that antitrust regulations have proven to be a significant barrier to our obtaining access to more data. We hope you will keep these limitations and restrictions in mind and recognize the good faith effort ACEP undertook to try and meet the Workgroup's request.

If you have any questions, please contact Laura Wooster, ACEP's Associate Executive Director of Public Affairs at lwooster@acep.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Vidor E. Friedman". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Vidor E. Friedman, MD, FACEP
ACEP President

Responses Enclosed:

[Question 1](#)

[Question 3](#)

[Question 4](#)

[Question 5](#)

[Question 6](#)

[Question 7](#)

[Question 8](#)

[Question 9](#)

[Question 10](#)

[Question 11](#)

[Question 12](#)

[Question 13](#)

[Appendix 1](#)

1) **What is the average out-of-network payment that your providers receive for emergency services? How does this compare to Medicare and charges, broken down by plan type and market? How does this differ by state?**

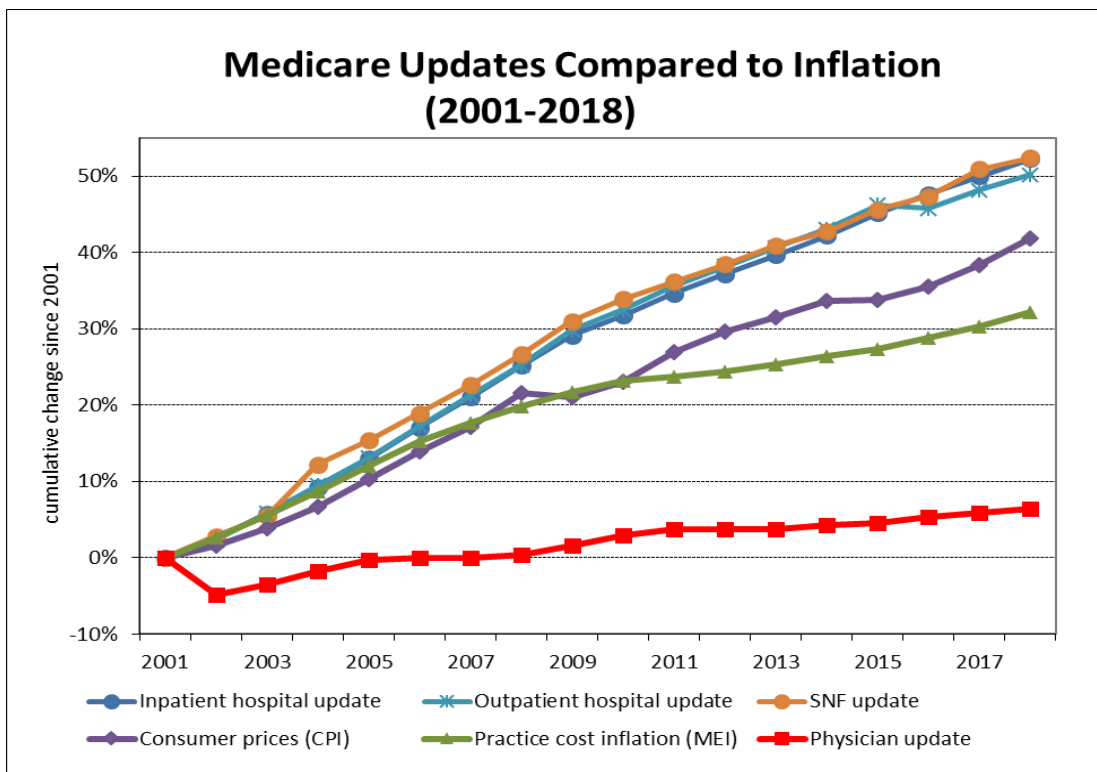
The following tables show for a selection of states the average in-network (i.e. allowable) contracted amount as well as the 80th percentile of charges (a commonly used benchmark in some states for Usual, Customary, and Reasonable, or UCR) from the FAIR Health database. The table includes the Level 3, 4, 5, and Critical Care CPT code and the corresponding average in-network payment as well as charge for a selection of geozips. Level 1 and Level 2 visits are excluded because combined they account for less than 5 percent of emergency visits. For context, a Level 5 would typically be used for heart attacks, strokes, overdose, and other such life-threatening conditions.

When comparing these numbers across the columns in the tables, there are several considerations to keep in mind. The *average* allowable amount does not show the broad range and variation that exists among contracted allowables. Even within a particular geographic area there can be a several fold difference between the lowest contracted allowable rate, and the highest—due largely to different payers, plan designs, and products. The charge and corresponding out-of-network payment by health plans must be higher than the highest contracted allowable rate, otherwise health plans will no longer have any incentive to contract. So, if you have an *average* contracted allowable amount of \$500 for level 5, but the highest contracted allowable amount for the *range* in that geographic area is \$800, then the charge in that area will likely be above \$800.

Alaska			
ZIP	Visit Severity	FAIR Average Allowables	Health 80th Percentile Charges
995XX	Level 3	\$267	\$693
	Level 4	\$367	\$725
	Level 5	\$894	\$1,057
	Critical Care	\$618	\$1,219
996XX	Level 3	\$226	\$510
	Level 4	\$359	\$754
	Level 5	\$488	\$1,034
	Critical Care	\$587	\$1,213
997XX	Level 3	\$198	\$533
	Level 4	\$450	\$624
	Level 5	\$446	\$928
	Critical Care	\$553	\$1,086
998XX	Level 3	\$227	\$529
	Level 4	\$373	\$790
	Level 5	\$575	\$1,213
	Critical Care	\$769	\$1,592
999XX	Level 3	\$331	\$739
	Level 4	\$532	\$1,107
	Level 5	\$684	\$1,424
	Critical Care	\$573	\$1,458

Additional tables for Colorado, Connecticut, Delaware, Indiana, Louisiana, New Hampshire, and New York can be accessed in [Appendix 1](#).

With regard to how these payments compare to Medicare reimbursement, Medicare rates were never intended to reflect market rates, but rather are based on the amount of money that is available in the federal budget. Medicare therefore has not kept pace with inflation. According to data from the Medicare Trustees, Medicare physician pay has barely changed over the last decade and a half, increasing just 6 percent from 2001 to 2018, or just 0.4 percent per year on average. In comparison, Medicare hospital pay has increased roughly 50 percent between 2001 and 2018, with average annual increases of 2.5 percent per year for inpatient services, and 2.4 percent per year for outpatient services. In short, Medicare physician pay doesn't go nearly as far as it used to. Adjusted for inflation in practice costs, **Medicare physician pay has declined 19 percent from 2001 to 2018, or by 1.3 percent per year on average.** Medicare rates were also not designed for the general population, but instead were created for an age-specific group to ensure vulnerable, elderly patients can afford quality care. It was never intended to represent the fair market value of healthcare services or fully cover provider costs for the general population.



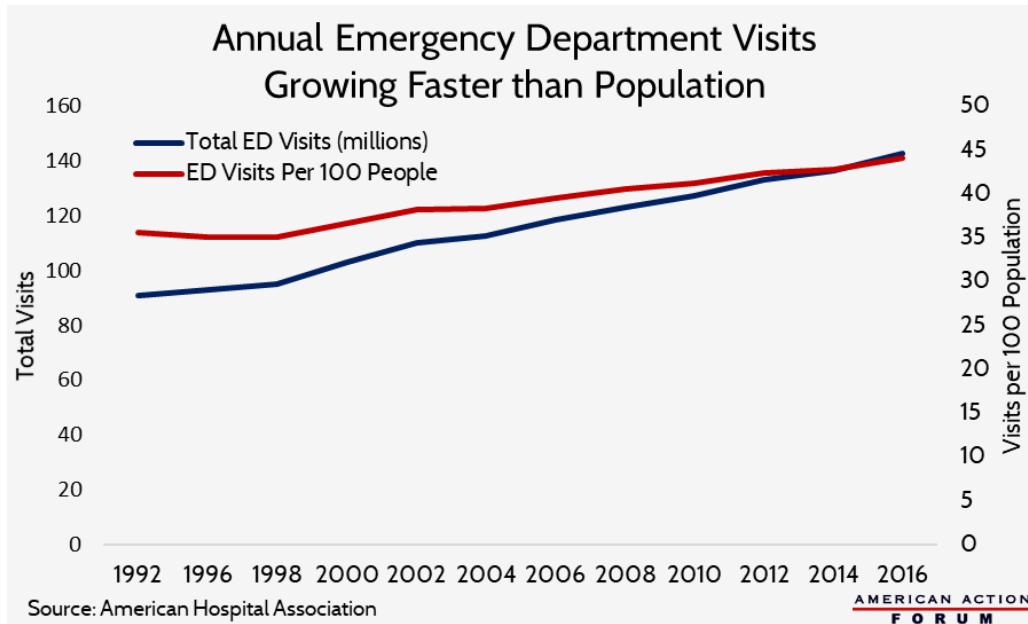
Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

- 3) According to an article published by the Health Care Cost Institute, emergency room spending per person has increased by 98% while overall emergency room utilization remained the same between 2009 and 2016. How do you explain this trend?

As the Health Care Cost Institute ([HCCI](#)) itself points out in the [Methods Notes](#) of the study (emphasis added), “these costs represent **the facility fee** for an ER visit – the cost of receiving care in an ER instead of a doctor's office. They do not include the costs of other services patients received during their visit to the ER such as the cost of an injected drug. Therefore, **these price and spending measures may not capture the entirety of what is typically thought of as an ER visit.** Patients may often receive multiple ER CPT codes during the same visit.”

The professional fee, or the portion of the cost of care that emergency physicians, is entirely absent from the analysis or the article. Because ACEP represents only emergency physicians, we are not positioned to offer any perspective on potential trends of emergency department (ED) *facility* fees in the cited time period.

We do note, though, that the HCCI data is drawn from claims of employer-sponsored private health insurance from only four major insurers¹, and perhaps as a result of this limited data set, some of the noted trends do not align with other statistics and tracking from the same time period. For example, HCCI states that overall ED utilization remained flat from 2009 to 2016. Yet several other data sources show otherwise, including the American Hospital Association, the Centers for Disease Control and Prevention (CDC), and AHRQ.



The American Hospital Association showed an increase in ED visits from 2009 to 2016 from 127.3 million to 142.6 million². The CDC’s National Hospital Ambulatory Medical Care Survey showed a 10 percent increase in emergency department volume from 2010 to 2016^{3,4}. And the AHRQ’s Healthcare Cost and Utilization Project⁵ showed an increase in ED visits from 2009 to 2014 (the latest year available) of just over 20 percent.

As well, it’s important to keep in mind that professional fees (i.e. the physician’s) only represent a small fraction of the total cost of care. From 2007 to 2014, hospital prices overall grew 42 percent, while physician prices rose 18 percent. And for hospital-based outpatient care (including that provided in the emergency department), hospital prices grew 25 percent, while physician prices grew 6 percent⁶.

Yet leaving aside the issue of whether volumes have increased or remained the same, there has been a marked (and well-documented) shift of ED patients being sicker over the past decade, as strong efforts by payers to keep all but the sickest patients out of the ED. In addition, lower acuity patients have begun to go to alternative sites

¹ 2016 Health Care Cost and Utilization Report; Analytic Methodology 2016V1.0; January 23, 2018. [Accessed online](#) 2.15.19.

² Analysis of American Hospital Association Annual Survey data, 2016, for community hospitals. US Census Bureau: National and State Population Estimates, July 1, 2016. <https://www.aha.org/system/files/2018-07/2018-chartbook-table-3-3.pdf>

³ 2015 NHAMCS Emergency Department Summary Tables; https://www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf

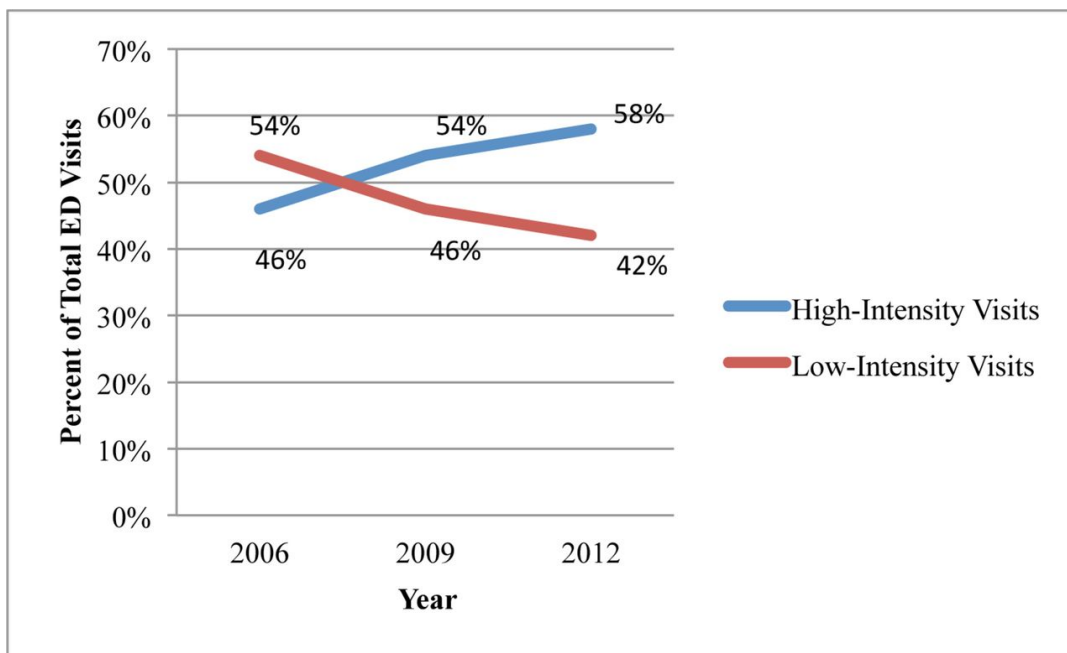
⁴ 2016 NHAMCS Emergency Department Public Use File; ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/NHAMCS

⁵ HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD; <https://hcupnet.ahrq.gov>

⁶ “Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care In 2007-14”. Health Affairs. February 5, 2019.

of care such as urgent care centers, minute-clinics, and extended-hour primary care physician offices. As a result of payer behavior, including benefit design, some patients may even delay care for fear of their insurance plan denying any coverage if the visit is retroactively deemed to be non-emergency. Patients are afraid to be stuck with a big bill and only seek emergency care when their condition worsened, resulting in more patients coming to the ED with more severe illnesses, which require higher levels of care.

Patients presenting to urgent care clinics and offices that provide after-hours care are usually lower acuity. Visits to ED for the treatment of low-acuity conditions decreased by 36% from 2008 to 2015 (from 89 visits per 1000 members in 2008, to 57 visits per 1000 members in 2015)⁷. Whereas use of non-ED venues *increased* by 140% in the same time period. Removing these cases treated at other venues from the denominator of ED analyses results in the shift of remaining higher acuity patients. Between 2006 and 2014⁸, there was a significant decline in the rate of visits for sprains, strains, superficial contusions, and skin wounds and significant increases in visits for abdominal pain, chest pain, multiple categories of infection, and COPD (i.e. emphysema)—even a 74% increase in the rate of ED visits for sepsis alone.



As well, the work of ED evaluation and management has changed significantly over the past 10 years, requiring greater cognitive work and creating higher levels of stress and risk for emergency physicians, as they now make the majority of hospital admission decisions in the United States. Studies identify multiple areas of increased intensity of services in diagnosis and treatment, resulting in longer, more complex ED evaluations, and patients who were previously hospitalized being discharged home, demonstrated by no increase in the overall rate of hospital admission, greater numbers of diagnostic tests and interventions, and a higher rate of ICU admissions⁹.

⁷ Poon SJ, Schuur JD, Mehrotra A. Trends in Visits to Acute Care Venues for Treatment of Low-Acuity Conditions in the United States From 2008 to 2015. *JAMA Intern Med.* 2018;178(10):1342–1349. doi:10.1001/jamainternmed.2018.3205

⁸ Moore BJ (IBM Watson Health), Stocks C (AHRQ), Owens PL (AHRQ). Trends in Emergency Department Visits, 2006-2014. HCUP Statistical Brief #227. September 2017. Agency for Healthcare Research and Quality, Rockville, MD

⁹ Pitts SR1, Pines JM, Handrigan MT, Kellermann AL “National trends in emergency department occupancy, 2001 to 2008: effect of inpatient admissions versus emergency department practice intensity” *Ann Emerg Med.* 2012 Dec; 60(6):679-686.e3. doi: 10.1016/j.annemergmed.2012.05.014. Epub 2012 Jun 20.

Significant changes in the standard of care have resulted in more ED ancillary studies, more complex ED medical evaluation and treatment, and more ED diagnostic and therapeutic interventions. Technology - including special studies such as high-resolution CT scans, MRIs, ultrasounds, treadmill and nuclear cardiac stress tests - has allowed for rapid and accurate ED diagnoses and treatment¹⁰. What is often forgotten is that frequently ED medical evaluations and treatment can often *prevent* admission to a hospital, leading to overall cost savings. A research paper notes, “Our findings suggest that the growth in high-intensity billing has been accompanied by an observable increase in diagnostic and treatment intensity while admission rates have fallen.”¹¹

A recent RAND report found that emergency physicians became major decision maker for more than half of U. S. hospital admissions starting in 2007, and suggests that more patients who previously would have been admitted to the hospital by their office-based physicians are being sent to the ED, leading to a 20 percent rise in non-elective admissions through the ED, as well as a 24 percent *decrease* in admissions directly from outpatient settings¹². **On average, an inpatient stay is ten times costlier than a visit to the emergency department.**¹³

These two factors (a shift of patients with more severe acuity, and an increase in evaluation and management work and complexity) together account for much of the increase in cost of care provided in emergency departments over the past decade.

4) What percentage of ER, radiology, anesthesiology, and pathology services are performed by providers that are part of outsourcing firms? For each of these specialties, what are the relative market shares for the large national staffing companies, local or regional physician groups, and hospital-staffed specialists? For providers employed by those firms, what percentage share the network status of the facility where they are practicing?

For emergency care, we have limited information on what percentage of it is performed by providers that are not directly employed by a hospital. In a 2013 report¹⁴, Deutsche Bank estimated that “roughly 65% of the physician market is outsourced”, with estimates that across the United States, 35% of ED physicians are self-employed, 12% work for regional groups, 31% work for local groups, and 22% work for national firms. Physician training, management, and ongoing professional development are different than managing a facility, which over the last few decades has driven a trend toward outsourcing. As noted in another report, outsourcing “is primarily driven by the difficulty of efficiently staffing and managing an ED; for many hospitals, this department is its most unprofitable unit. Yet efficient EDs (i.e. those with high throughput and strong customer satisfaction) are a critical function of the hospital.”¹⁵

¹⁰ Pines, Jesse M., et al. "National trends in emergency department use, care patterns, and quality of care of older adults in the United States." *Journal of the American Geriatrics Society* 61.1 (2013): 12-17.

¹¹ Burke LG, Wild RC, Orav EJ, et al Are trends in billing for high-intensity emergency care explained by changes in services provided in the emergency department? An observational study among US Medicare beneficiaries *BMJ Open* 2018;8:e019357. doi: 10.1136/bmjopen-2017-019357

¹² Morganti, K.G., Bauhoff, S., Blanchard, J.C., Abir, M., Iyer, N., Smith, A., Vesely, J.V., Okeke, E.N. and Kellermann, A.L., 2013. “The evolving role of emergency departments in the United States.” *Rand health quarterly*, 3(2).

¹³ Morganti, K., Bauhoff, S., Blanchard, J., Abir. “The Evolving Role of Emergency Departments in the United States”. RAND Corporation. 2013; See also Attachment 2 (graph illustrating care for the uninsured).

¹⁴ Deutsche Bank (2013). *Markets Research - Envision Healthcare*.

¹⁵ Cooper, Zack, Fiona Scott Morton, and Nathan Shekita. 2017. “Surprise! Out-of-Network Billing for Emergency Care in the United States.” NBER Working Paper 23623.

We are unable to provide data on the percentage of physicians at a hospital that share the network status of the facility where they practice, since hospitals and physician groups are independent of one another. As well, the timelines for contracting for a particular hospital with various insurers will be independent of those for the hospital with any physician groups with which it might contract. It is therefore particularly difficult for those on the provider side to accurately measure the extent of alignment between hospital, payer, and physician group network status.

Finally, it is worth noting that there is typically a significant amount of pressure placed on emergency physician groups to be in-network at an in-network hospital. Even when in-network rates are low or even unsustainable, local market dynamics promote participation.

- 5) **What percentage of amounts paid for overall emergency care, by both patients and payors, can be attributed to balance billing (dollar amounts and/or percentage amounts)? How about for other specialty departments (e.g., anesthesiology, radiology, pathology, etc.)? If possible, please provide data showing the amounts (or percentages of overall emergency care) paid for services by out-of-network providers at in-network facilities, as well as in-network providers at out-of-network facilities. If possible, please provide data to compare private versus public payments in these scenarios. Please also provide a breakdown of surprise medical bills attributable to each provider specialty.**

Because terms such as “balance bill” and “surprise bill” can be sometimes confused with each other, it’s important to clearly define each before providing perspectives on each:

- **Balance bill:** The amount, if any, that a provider bills a patient for an out-of-network claim that is attributed to the difference between the provider’s charge and the rate the insurance company unilaterally decides is the allowed benefit for that service. A balance bill does *not* include patient cost-sharing attributed to the allowed benefit, such as deductible, co-pay, or co-insurance.
- **Surprise billing:** A patient is billed for a medical service that he believed was covered and would be paid for by insurance. Surprise billing is often due to high deductibles, high cost-sharing, and/or may be due to balance billing if the patient was not aware the service would generate a balance bill. Finally, recall that a “Balance” is not always billed to the patient. A provider may simply elect to accept the amounts received, and not bill the patient any remaining Balance.

In short, not all balance bills are surprise bills—many patients purposefully seek scheduled care from an out-of-network provider who meets their particular needs, and will therefore expect a balance bill (without any surprise). As well, surprise billing can occur with or without a balance bill, and from both in- and out-of-network care.

Often *any* bill following emergency care is a surprise to the patient, who assumed that their insurance coverage would only be subject to the (for example) \$150 copay that is listed on their benefits card. This is why the ACEP Framework calls for insurers to be required to include the policyholder’s in- and out-of-network deductibles for emergency care on the benefit card, to at least make it clearer to that policyholder what the limits of their insurance coverage really is, and the amounts of cost-sharing they will be personally liable for should they require emergency care.

Some specific scenarios of surprise bills in emergency care are as follows:

- A. A patient receives emergency care at an in-network facility, is seen early in the health plan’s insurance year (say, in January) by an in-network emergency physician, but has an in-network deductible of \$2,000.
 - The physician charge is \$600, the contracted rate with the insurer is \$400. As noted the in-network deductible is \$2,000, so patient receives a surprise bill of \$400. Insurance pays \$0 (since patient has not met his deductible), so patient pays the entire \$400.
 - \$400 is then applied to the patient’s in-network deductible, so he still has \$1,600 remaining deductible before seeing any benefit for the premium paid.
- B. A patient receives emergency care at an in-network facility, is seen by an out-of-network emergency physician, and has an out-of-network deductible of \$4,000.
 - The physician charge is \$900, insurance determines the allowed amount is \$200. As noted the deductible is \$4,000, so the patient receives a surprise bill of \$900 of which \$200 is deductible and \$700 is the balance bill. Insurance pays \$0 (since the patient has not met her deductible), so patient pays entire \$700.
 - Only \$200 is then applied to her out-of-network deductible. Patient still has \$3,800 remaining deductible before seeing any benefit for the premium paid
- C. A patient receives emergency care late in the year at an in-network facility, is seen by an in-network emergency physician, has met her in-network deductible of \$2,000 but *not* her out-of-network deductible of \$4,000, and has advanced imaging as part of her emergency care that is read by a radiologist who is out-of-network.

The question asks for a breakdown of “surprise” medical bills attributable to emergency medicine. While we have no estimates ourselves of the frequency of surprise bills in emergency medicine, one study¹⁶ found that the *potential* for a surprise medical bill (“PSMBS” in the table below) for emergency care in various scenarios occurred at the rates in the table.

ER Outpatient Cases by Network and Payment Status								
Includes only outpatient ER cases for patients with network-based health insurance. Counts are unweighted frequencies from the MarketScan data. Percentages are weighted means using the MarketScan National Weights								
	2007	2008	2009	2010	2011	2012	2013	2014
Total Cases	6,770,122	10,051,680	11,392,179	10,993,842	11,582,030	12,029,916	8,782,054	9,853,921
Cases with Missing Network Status*	1,735,376	2,414,493	3,145,393	2,945,505	3,191,367	3,396,060	2,101,063	3,004,522
Remaining Cases	5,034,746	7,637,187	8,246,786	8,048,337	8,390,663	8,633,856	6,680,991	6,849,399
All Services IN	58.9%	72.4%	73.4%	75.1%	78.4%	79.9%	79.5%	81.2%
ER ON, No Ambulance	23.4%	11.1%	10.3%	9.7%	5.6%	4.8%	5.1%	5.0%
PSMBS:								
ER ON, Ambulance	1.2%	0.5%	0.5%	0.6%	0.4%	0.4%	0.4%	0.4%
ER IN, ER Physician ON	9.2%	7.9%	7.9%	7.1%	8.1%	7.6%	7.3%	6.0%
ER & ER Physician IN, other	5.3%	6.0%	5.8%	5.7%	5.6%	5.6%	6.2%	6.2%

Note that this study has significant limitations in that it is based only on claims from those with employer-sponsored insurance coverage, and none from those with individual market coverage (which tend to have narrower networks and more potential for a surprise bill. More importantly, it does not account for any potential for a surprise medical bill where a patient has not yet met their deductible.

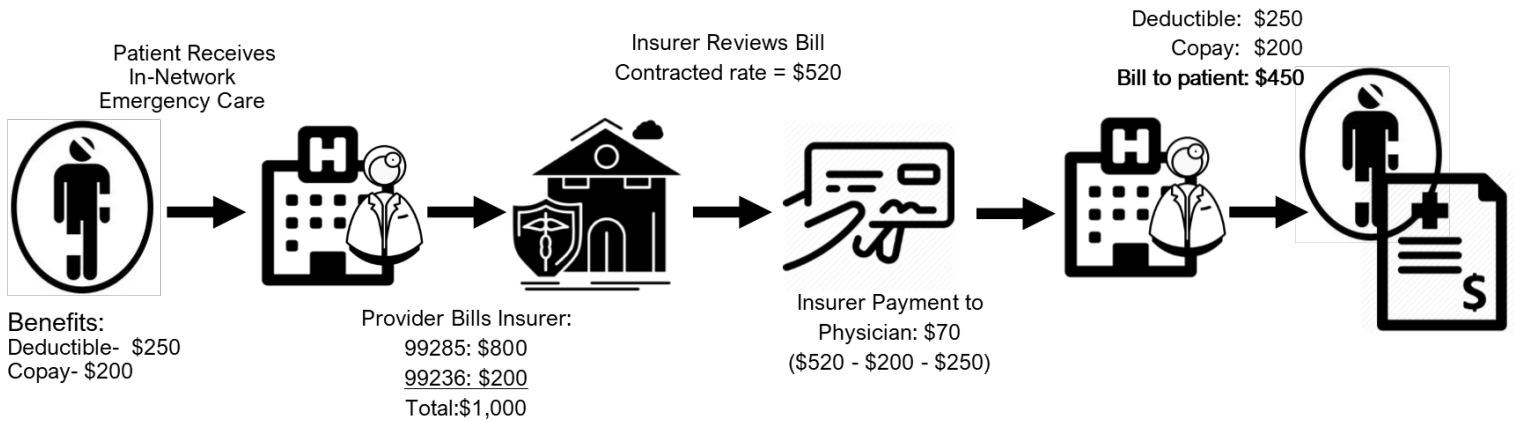
¹⁶ One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills. Garmon C, Chartock B. Health Aff (Millwood). 2017 Jan 1;36(1):177-181. doi: 10.1377/hlthaff.2016.0970. Epub 2016 Dec 14.

6) In situations where the ED or ancillary physician is out-of-network but the facility is in-network, can you provide data to show how often a balance bill is sent to the patient?

In addition to the data limitations noted in the previous question, the emergency physician group will not know the contract status of the hospital for patients it has billed an insurer for. Therefore it is difficult to provide any estimates of how often a balance bill is sent to the patient when the ED physician is out-of-network but the facility is in-network.

7) What percentage of care provided in the emergency department results in bad debt from patients not paying their part of what is owed from care they received, from missed copayments, denied claims, or other means?

Bad debt can result from a patient not paying their part of what is owed from emergency care they received as a result of any of the scenarios illustrated in [Question 5](#), as well as additional scenarios such as a lack of any insurance coverage (which can be as high as 25 to 30 percent depending on the particular hospital or region), or [retroactive denials](#) by an insurer [such as Anthem](#) for so-called “nonemergency” care who have instituted such policies that violate the prudent layperson standard that is in federal law^{17,18}.



In the graphic above, a patient receives in-network emergency care. Even though the rate contracted for that service between the insurer and provider is \$520, the emergency physician will only receive \$70 from the insurer directly. The patient is responsible for meeting his deductible and copay, which in this case total \$450. The provider must now recoup that \$450 by billing the patient directly for his cost-sharing. Emergency physician groups report that patients only pay approximately 30 to 40 percent of their cost-sharing obligations.

In addition, many insurance plans send the insurance payment to the patient, rather than the provider who delivered the medical care. That money rarely comes back to the physician group, as the patient might use it to pay other more pressing bills, resulting in additional difficulty collecting even the amount unilaterally determined by the insurance plan, and further increasing bad debt for the emergency provider.

¹⁷ [An ER visit, a \\$12,000 bill — and a health insurer that wouldn't pay](#): A new insurance policy expects patients to diagnose themselves; Vox.com; Sarah Kliff, Jan 29, 2018.

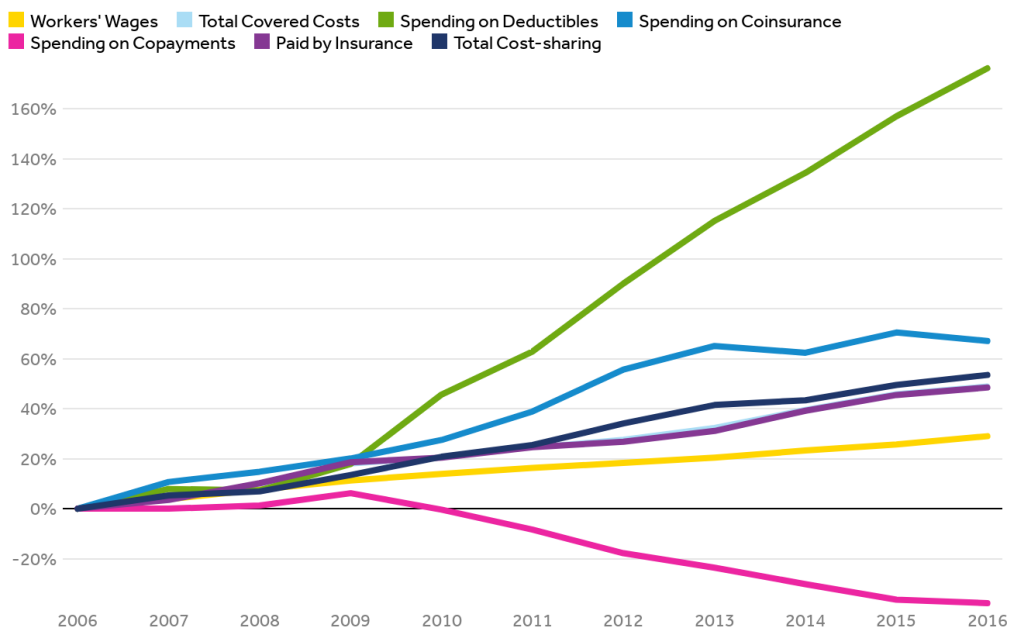
¹⁸ [Is it an emergency? Insurer makes patients question ER visit](#); Associated Press; Tom Murphy, November 9, 2017

And of most significance, insurance design changes in recent years have raised deductibles to amounts far beyond what the average American can pay. As noted recently by the Kaiser Family Foundation (emphasis added),

“...from 2006 to 2016, average payments for deductibles and coinsurance among people with large employer coverage rose considerably faster than the total cost for covered benefits; however, the average payments for copayments fell during the same period. As can be seen in the chart below, over this time, **patient cost-sharing rose notably faster than insurer payments for care as health plans have become a little less generous in this regard.**”

This exponential skyrocketing of deductibles (top or green line in graph below) has resulted in a corresponding increase in the amount of bad debt that emergency physicians incur.

Cumulative increases in health costs, amounts paid by large employer insurance coverage, amounts paid for cost sharing and workers wages, 2006-2016



Source: Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2006-2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 2006-2016. • Get the data • PNG

Peterson-Kaiser Health System Tracker

As well, reimbursement from Medicare has not kept pace with practice costs (as detailed in [Question 1](#)), and Medicaid rates are so low in many states that it can sometimes cost an emergency physician group more in administrative time and expense to submit a claim for reimbursement than it will receive back. Even pre-ACA, in 2009 it was estimated that patients covered by these programs are cared for in the emergency department at a substantial financial loss: -15.6 percent for Medicare, and -35.9 percent for Medicaid¹⁹. Given the further decline in Medicare reimbursements since then, as well as Medicaid expansion in many states that greatly increased the proportion of Medicaid patients, such losses continue to grow. Emergency physicians are the only safety net for many in our country, including vulnerable uninsured, Medicare, Medicaid, and pediatric patients. Should commercial insurance reimbursement rates be further scaled back, it will be very difficult to keep the doors open

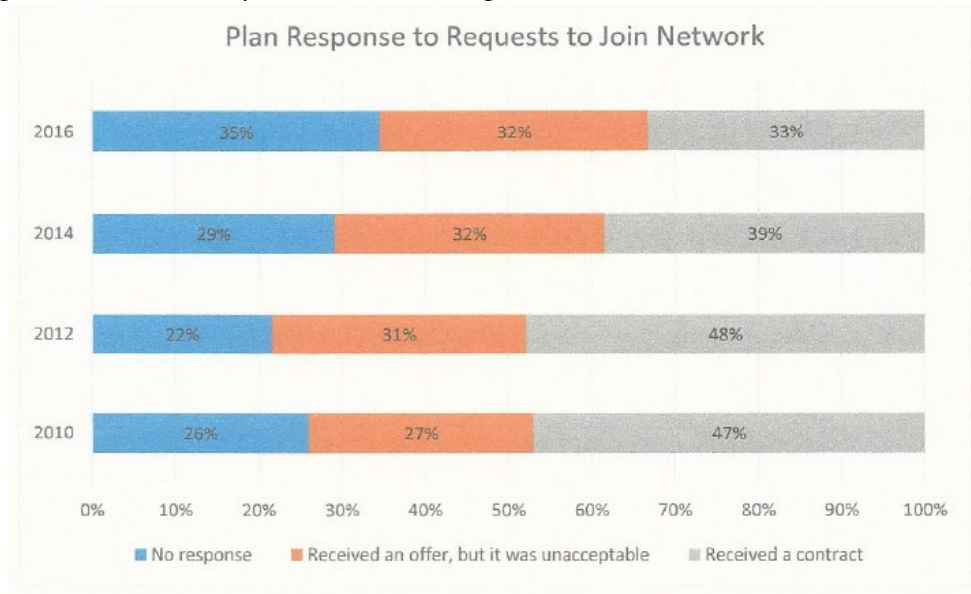
¹⁹ Wilson, M. and Cutler, D. “Emergency department profits are likely to continue as the Affordable Care Act expands coverage.”Health affairs(Project Hope) vol. 33,5 (2014): 792-9

24 hours a day, seven days a week, and 365 days a year in many emergency departments, especially those in rural or urban underserved areas.

While patient cost-sharing as a part of health insurance benefit structure can help incentivize patients to make better and lower-cost decisions when seeking *scheduled* health care, there are significant limitations to its effectiveness in an emergency. Due to the Emergency Medical Treatment and Labor Act – or EMTALA – emergency providers are prohibited from discussing with the patient any potential costs of care or details of their particular insurance coverage until they are screened and stabilized. This is an important patient protection that helps ensure their care stays focused on their immediate medical needs. But it also means that patients may not fully understand the costs involved in their care until they get the bill.

8) What specific recommendations do you have to facilitate in-network contracting between providers and plans in the context of federal legislation to address surprise medical billing?

A 2016 survey of physicians in Texas by the Texas Medical Association found among physicians who approached a plan in an attempt to join its network, **35 percent received no response from the plan**—this was an increase of 6 percentage points from a survey in 2014, and a 13-point increase from 2012.



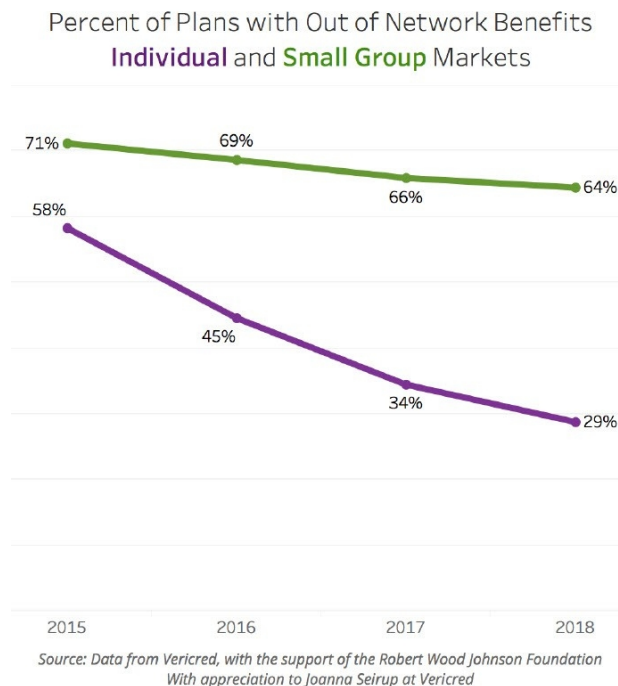
As can be seen in the chart above, the percentage of surveyed physicians who received a contract correspondingly decreased over the same years, yet the percent who received an offer from the insurance plan but found it unacceptable (i.e. turned it down) remained stable. From this, we can draw the conclusion that the majority of physicians are continuing to make good faith efforts to be in-network, but are being met with growing resistance from the insurance plans.

This is even more of an issue when it comes to emergency care. Under EMTALA, insurance companies are ensured their policyholders are able to access emergency care, and therefore have no real incentive beyond what poorly defined or enforced state network adequacy requirements might exist. The insurers are further incentivized to keep their networks narrow since if a policyholder’s emergency care 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 encounter to the patient, rather than the insurer (see [Question 5](#) for examples of how this plays out). This significantly tilts the contract negotiations playing field in favor of payers. In fact, because of this difference in

deductible levels, **even if the allowable amount paid by the insurer for out-of-network emergency care is higher than an in-network contracted rate would have been, the insurer *still* pays less for that emergency episode.**

We therefore offer the following specific recommendations to facilitate in-network contracting between plans and emergency providers:

Level Deductibles: OON deductibles are generally high, particularly in the individual market, where the median OON deductible is approximately \$12,000. In about 30 percent of individual market plans with OON coverage, the deductible is greater than \$20,000. The small group market is quite different has a median deductible of about \$6,000 and virtually no deductibles higher than \$20,000. Many plans in the small group and individual market do not have any OON coverage at all, and for those that do, the coverage tends to be minimal. For example, the number of ACA plans offering *any* out-of-network coverage declined from 58 percent in 2015, to 29 percent in 2018²⁰.



While current law requires patient cost-sharing to be the same for in- or out-of-network emergency care, it actually defines cost-sharing in that section (Public Health Service Act Sect. 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. Therefore, **we believe the equal cost-sharing provision in Section 2719A should be extended to deductibles.** By leveling these deductibles whether the emergency patient is in- or out-of-network, insurers will have a greater incentive to negotiate fairly with emergency physician groups who seek to go in-network.

Strengthen and Enforce Network Adequacy: Additionally, network adequacy requirements must not only be strengthened, but also enforced. The ACA set a national standard for network adequacy requiring “a network that

²⁰ Hempstead, K. “Percent of Plans with Out-of-Network Benefits: To Infinity and Beyond: Exposure to Out-of-Network Bills Is High and Rising in the Individual and Small Group Markets”; Robert Wood Johnson Foundation Marketplace Pulse. October 4, 2018. <https://www.rwjf.org/en/library/research/2018/10/percent-of-plans-with-out-of-network-benefits.html>

is sufficient in number and types of providers,” and that “all services will be accessible without unreasonable delay.” But states were left to interpret “sufficient” and “reasonable”, to varying results.

Narrow networks as a cost-saver by insurers is a significant and growing cause of patients receiving surprise bills, and increase the likelihood that providers are out of network. A 2016 analysis notes (emphasis added), “To date, consumers have had little indication of network size when choosing a plan. Many marketplaces have a feature that allows consumers to search for a specific provider or to see all participating providers by specialty, **but the overall breadth of the network remains opaque.**”²¹ See the following question for a comparison of states that had a higher incidence of potential surprise bills with those who have the narrowest networks.

Avoid a Benchmarking Out-of-network Payment Formula

In order to encourage contracting, rigid benchmarks that cap or set a specific formula for payment for physicians treating out-of-network patients should be avoided. Such benchmarks if set too low will disincentivize fair contract negotiations on the part of insurers. If too high, providers may not be incentivized to negotiate in good faith. A benchmark once put into place will also have a ripple effect on future contracts, since the out-of-network payment rate becomes the new natural “high” in a geographic area, and future in-network contracts will always be lower. As this continues year-over-year, there will be downward spiral with disastrous consequences for maintaining patient access to emergency care.

ACEP instead recommends a “baseball-style” alternative dispute resolution process such as that used in New York State since 2015 (see [Question 12](#) for more detail), which has worked to ensure a fair and level-playing field that incentivizes insurers and physicians to come to the table for fair negotiations and contracting.

9) What percentage of care provided by providers within each specialty is out-of-network? Broken down by each specialty, what share of providers are out-of-network for 0-10%, 10-25%, 25-50%, or more than 50% of the commercially insured patients (not including Medicaid managed care) they see?

We unfortunately do not have access to such estimates.

10) Can you identify specific states where providers have a lower-than-average contracting rate?

For reasons that remain unclear, discussions of surprise billing often focus only on the *provider* role in the contracting process, and not also on the insurer. We therefore would reframe this question as asking to identify specific states where *insurers* have a lower-than-average contracting rate, i.e. a narrow network.

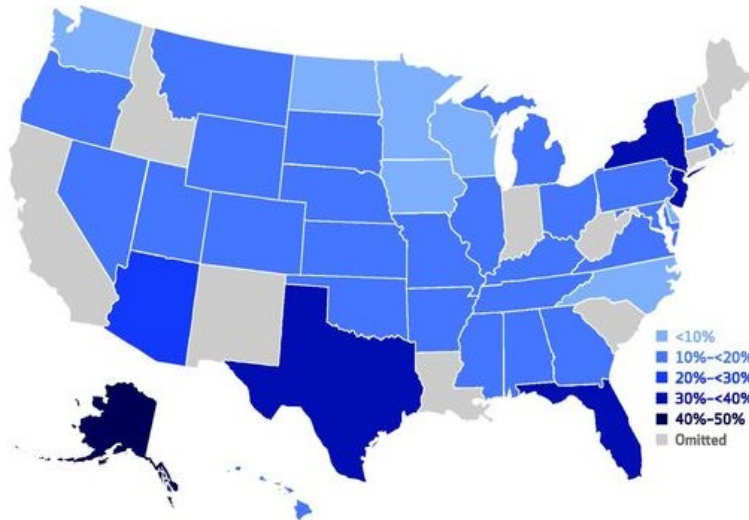
[Question 8](#) discussed the challenges Texas physicians have faced in even receiving a response when trying to contract with insurers. We unfortunately do not have similar data for other states, but a recent paper from the University of Pennsylvania provided state-by-state estimates of the percentage of narrow networks for 2016. It is interesting to compare this breakdown with a map of 2014 potential medical surprise bills from the paper²² discussed in [Question 5](#). While unfortunately we do not have state-by-state estimates of narrow networks for the same year, 2014, there is still a significant amount of correlation, which is not surprising—**narrow networks**

²¹ Marketplace Plans With Narrow Physician Networks Feature Lower Monthly Premiums Than Plans With Larger Networks <https://ldi.upenn.edu/brief/marketplace-plans-narrow-physician-networks-feature-lower-monthly-premiums-plans-larger>

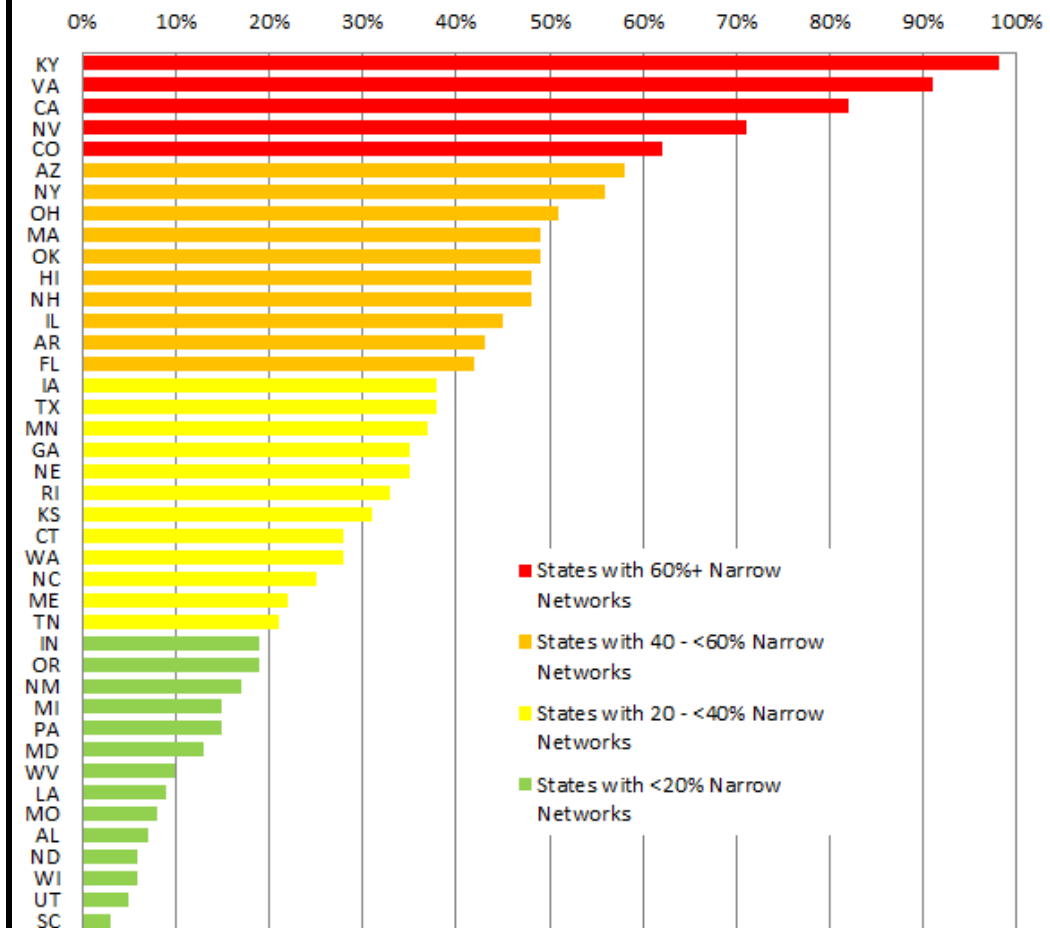
²² One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills. Garmon C, Chartock B. Health Aff (Millwood). 2017 Jan 1;36(1):177-181. doi: 10.1377/hlthaff.2016.0970. Epub 2016 Dec 14.

increase the potential for surprise medical bills. Given that network design and other insurance trends have only further narrowed networks since 2014 (and 2016), we expect the concentrations would be even higher today.

Exhibit 3 State levels of hospital inpatient admissions from the emergency department with potential surprise medical bills, 2014



Percent of Narrow Networks by State in 2016



11) What role do you think that hospitals should play in combatting surprise medical billing?

As in the previous question, once again discussion around surprise billing seems focused only on providers and what they should do differently to combat it, and not also on the insurer. Recently there have been some who propose hospitals should require any physician groups they contract with to be in-network with any insurers the hospital has gone in-network with. This would be problematic for several reasons:

- It would further distort the contracting dynamic between emergency physician groups and insurers. This dynamic is already heavily in the insurer's favor due to EMTALA ensuring their policyholders will receive emergency care regardless of network status, as well as due to the incentive discussed in [Question 8](#) for insurers to keep emergency physicians out-of-network so that policyholders with a higher out-of-network deductible pay for a greater portion of the cost of their emergency visit themselves (rather than the insurer). If added, such a coercive requirement would completely remove the physician group's ability to negotiate a contract, as the insurer would know the hospital is requiring the contract, and would therefore offer only the most unfavorable terms.
- It would be difficult to operationalize, especially from a timing perspective. Hospital contracts with insurers can be multi-year, so there would too often be scenarios where the hospital has dropped or changed a contract with a particular insurer, yet the physician group contract with that same insurer would not yet have expired, or vice-versa.
- Perhaps most importantly, in a number of states such a requirement would be against state law.

12) In your view, is there a state model that has worked particularly well at protecting patients from surprise medical billing? If so, why has it worked well? Please provide the details of this model, including its impact on contracting rates and out-of-network payment rates, and describe the data and policy rationale underlying this state legislation.

There are certain states across the country that have taken a comprehensive approach towards eliminating the practice of balancing billing and taking the patient out of the middle of billing disputes. ACEP believes that two states, New York and Connecticut, have adopted laws that should inform federal legislation.

New York: In 2015, New York implemented a law that banned balanced billing and established an arbitration process for out-of-network emergency services.

Not all claims are included in the independent dispute resolution (IDR) process. Smaller claims for emergency services that are currently less than \$683.22 (annually adjusted for inflation) and do not exceed 120 percent of "usual and customary cost" (UCR) are automatically exempted. UCR is defined as the 80th percentile of all charges for a health service rendered by a provider in the same or similar specialty and provided in the same geographic region as reported by a benchmarking database maintained by a nonprofit organization. New York identifies the FAIR Health charge database as an independent entity that can calculate UCR.

Under the established IDR process, the arbitrator picks either the charge set by the provider or the allowed amount offered by the insurer, without modification. The party whose amount is not chosen must pay for the cost of arbitration (estimated by the State of NY to range from \$225 to \$325 per appeal), as well as any outstanding amounts as a result of the decision.

This "loser pays" baseball-style arbitration process has proven to be an effective way of incentivizing providers to charge reasonable rates, while at the same time encouraging insurers to pay appropriate and reasonable amounts. Since both parties have this powerful incentive to act fairly, most claims do not even need to go into

the IDR process. As seen in the chart below, out of the millions of visits to the emergency department in 2018, only 849 emergency claims went to arbitration. As well, the decisions rendered on these were evenly split, further demonstrating that the system is working.

Emergency Services

Total received	849
Not eligible	162
Still in process	139
Decision rendered	548
Health Plan payment more reasonable	143
Provider charges more reasonable	176
Split decision	165
Settlement reached	64

The New York law has preserved access to emergency care and has not led to significant increases in insurance premiums. In fact, the Kaiser Family Foundation has shown that premiums in New York have grown more slowly than rates for the rest of the nation over the last five years.²³

Connecticut: The Connecticut law, passed in 2016, bans balanced billing and sets a minimum benefit standard for out-of-network emergency services based on the greatest of three payment amounts: 1) the in-network amount; 2) the usual, customary, and reasonable (UCR) rate; and 3) the Medicare amount. The UCR is defined in law as the 80th percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database.²⁴ Like New York, Connecticut has identified FAIR Health as the independent entity that should be used to determine UCR. FAIR Health data illustrate that provider charges in CT have not increased beyond the rate of inflation since the law was implemented.

Also included in Connecticut’s law are greater out-of-pocket protections for consumers. As previously noted in this response, under federal law, cost-sharing for out-of-network emergency services cannot be greater than cost-sharing for in-network emergency services but is defined as only the co-payment and co-insurance. Connecticut includes deductibles in the definition, along with co-payments and co-insurance. As stated above in response to [Question 8](#), we support a change in federal law that would level deductibles for out-of-network and in-network emergency services.

13) What percentage of balance bills are more than \$750?

The ACEP Framework recommends that an ADR process be paired with a “threshold” of \$750. Note that it is our intention that this threshold only apply *after* any patient cost-sharing is applied, similar to how New York’s threshold of \$683.22 operates for emergency services. As the NY State guidance states (emphasis theirs):

“Doctors. You may dispute the amount that the health plan pays you for emergency services through the independent dispute resolution process if you do not participate with a patient's health plan. However, the following emergency services are **exempt from the IDR process: CPT codes 99281 - 99285, 99288, 99291 - 99292, 99217 -**

²³ Kaiser Family Foundation (2015-2019): “Marketplace Average Benchmark Premiums,” <https://www.kff.org/e4f94bd/>

²⁴ Public Act No. 15-146, "An Act Concerning Hospitals, Insurers and Health Care Consumers,"

99220, 99224 - 99226, and 99234 - 99236 if the bill does not exceed 120% of the usual and customary cost and the fee disputed is \$683.22 (adjusted annually for inflation rates) or less after any applicable co-insurance, co-payment and deductible.”

So to return to our previous illustrative example in [Question 5B](#), that bill after patient cost-sharing is applied is \$700. Assuming that the billed charges were under 120% of the UCR, this bill would be exempt from the New York ADR process. Such an exemption for high-volume claims that are reimbursed at modest levels was included so that physicians would not be in a position of going to arbitration when the cost is higher than the potential benefit of winning an appeal against a health care plan. Without it, health plans would have an incentive to under-reimburse physicians, knowing that physicians would not have the financial resources to go through the IDR process. The threshold of \$750 in the ACEP Framework is intended to operate similarly.

In terms of the requested data on what percentage of balance bills for emergency care are more than \$750, it is very difficult to provide this information. As previously noted, a “balance bill” can mean many different things, and can be sent to patients even if their care was in-network, if they have not yet met their deductible. Even if one were to compare the 80th percentile of charges from the tables in [Question 1](#) with the average allowed amounts, looking at the difference between those numbers still does not provide any kind of accurate estimate of how many balance bills are under \$750, since patients’ deductibles and other cost-sharing amounts can span a very large range. As well, depending on the time of year or past medical expenses, a patient may have already met their deductible, or not.

Appendix 1

Colorado			
ZIP	Visit Severity	FAIR Health Average Allowables	FAIR Health 80th Percentile Charges
801XX	Level 3	\$131	\$351
	Level 4	\$225	\$665
	Level 5	\$334	\$981
	Critical Care	\$351	\$899
804XX	Level 3	\$148	\$351
	Level 4	\$290	\$665
	Level 5	\$441	\$981
	Critical Care	\$507	\$1,263
805XX	Level 3	\$112	\$234
	Level 4	\$212	\$443
	Level 5	\$309	\$649
	Critical Care	\$321	\$839
806XX	Level 3	\$159	\$364
	Level 4	\$253	\$568
	Level 5	\$389	\$856
	Critical Care	\$405	\$944
807XX	Level 3	\$159	\$364
	Level 4	\$253	\$568
	Level 5	\$389	\$856
	Critical Care	\$405	\$944
808XX	Level 3	\$128	\$277
	Level 4	\$227	\$510
	Level 5	\$348	\$759
	Critical Care	\$365	\$974
809XX	Level 3	\$128	\$277
	Level 4	\$227	\$510
	Level 5	\$348	\$759
	Critical Care	\$365	\$974
814XX	Level 3	\$124	\$336
	Level 4	\$195	\$450
	Level 5	\$298	\$655
	Critical Care	\$339	\$810
815XX	Level 3	\$124	\$336
	Level 4	\$195	\$450
	Level 5	\$298	\$655
	Critical Care	\$339	\$810
816XX	Level 3	\$182	\$581
	Level 4	\$299	\$734
	Level 5	\$445	\$1,087
	Critical Care	\$417	\$899

Connecticut			
ZIP	Visit Severity	FAIR Average Allowables	Health 80th Percentile Charges
060XX	Level 3	\$148	\$661
	Level 4	\$240	\$900
	Level 5	\$393	\$1,397
	Critical Care	\$213	\$581
061XX	Level 3	\$90	\$264
	Level 4	\$168	\$502
	Level 5	\$240	\$744
	Critical Care	\$236	\$605
062XX	Level 3	\$182	\$499
	Level 4	\$339	\$946
	Level 5	\$497	\$1,503
	Critical Care	\$384	\$1,539
063XX	Level 3	\$182	\$499
	Level 4	\$339	\$946
	Level 5	\$497	\$1,503
	Critical Care	\$384	\$1,539
064XX	Level 3	\$144	\$500
	Level 4	\$266	\$946
	Level 5	\$422	\$1,424
	Critical Care	\$336	\$1,704
065XX	Level 3	\$92	\$235
	Level 4	\$252	\$405
	Level 5	\$439	\$595
	Critical Care	\$439	\$1,105
066XX	Level 3	\$138	\$480
	Level 4	\$211	\$750
	Level 5	\$351	\$1,169
	Critical Care	\$295	\$695
067XX	Level 3	\$234	\$743
	Level 4	\$352	\$1,105
	Level 5	\$578	\$1,648
	Critical Care	\$244	\$602
068XX	Level 3	\$186	\$572
	Level 4	\$339	\$946
	Level 5	\$477	\$1,323
	Critical Care	\$256	\$690
069XX	Level 3	\$186	\$572
	Level 4	\$339	\$946
	Level 5	\$477	\$1,323
	Critical Care	\$256	\$690

Delaware			
ZIP	Visit Severity	FAIR Average Allowables	Health 80th Percentile Charges
197XX	Level 3	\$88	\$277
	Level 4	\$159	\$456
	Level 5	\$232	\$666
	Critical Care	\$417	\$1,473
198XX	Level 3	\$88	\$277
	Level 4	\$159	\$456
	Level 5	\$232	\$666
	Critical Care	\$417	\$1,473
199XX	Level 3	\$157	\$504
	Level 4	\$249	\$728
	Level 5	\$436	\$1,458
	Critical Care	\$322	\$1,294

Indiana			
ZIP	Visit Severity	FAIR Health Average Allowables	FAIR Health 80th Percentile Charges
460XX	Level 3	\$88	\$544
	Level 4	\$151	\$875
	Level 5	\$206	\$597
	Critical Care	\$244	\$590
462XX	Level 3	\$147	\$544
	Level 4	\$259	\$875
	Level 5	\$394	\$1,436
	Critical Care	\$258	\$590
464XX	Level 3	\$202	\$690
	Level 4	\$348	\$1,158
	Level 5	\$555	\$1,725
	Critical Care	\$300	\$837
466XX	Level 3	\$119	\$286
	Level 4	\$223	\$567
	Level 5	\$341	\$837
	Critical Care	\$351	\$1,030
468XX	Level 3	\$173	\$455
	Level 4	\$279	\$748
	Level 5	\$431	\$1,173
	Critical Care	\$302	\$748
469XX	Level 3	\$229	\$776
	Level 4	\$349	\$1,158
	Level 5	\$552	\$1,725
	Critical Care	\$510	\$1,887
473XX	Level 3	\$88	\$544
	Level 4	\$151	\$875
	Level 5	\$206	\$597
	Critical Care	\$244	\$590
475XX	Level 3	\$105	\$429
	Level 4	\$147	\$475
	Level 5	\$274	\$1,150
	Critical Care	\$259	\$538
478XX	Level 3	\$186	\$544
	Level 4	\$276	\$888
	Level 5	\$425	\$1,525
	Critical Care	\$306	\$1,315
479XX	Level 3	\$229	\$776
	Level 4	\$349	\$1,158
	Level 5	\$552	\$1,725
	Critical Care	\$510	\$1,887

Louisiana			
ZIP	Visit Severity	FAIR Average Allowables	Health 80th Percentile Charges
700XX	Level 3	\$194	\$717
	Level 4	\$410	\$1,360
	Level 5	\$566	\$2,007
	Critical Care	\$528	\$2,585
701XX	Level 3	\$153	\$717
	Level 4	\$269	\$1,360
	Level 5	\$434	\$2,007
	Critical Care	\$241	\$594
703XX	Level 3	\$232	\$739
	Level 4	\$401	\$1,360
	Level 5	\$596	\$2,007
	Critical Care	\$537	\$1,956
704XX	Level 3	\$218	\$702
	Level 4	\$371	\$1,244
	Level 5	\$595	\$1,838
	Critical Care	\$194	\$506
705XX	Level 3	\$232	\$739
	Level 4	\$401	\$1,360
	Level 5	\$596	\$2,007
	Critical Care	\$537	\$1,956
706XX	Level 3	\$232	\$739
	Level 4	\$401	\$1,360
	Level 5	\$596	\$2,007
	Critical Care	\$537	\$1,956
707XX	Level 3	\$152	\$537
	Level 4	\$260	\$831
	Level 5	\$395	\$1,232
	Critical Care	\$522	\$1,782
708XX	Level 3	\$199	\$757
	Level 4	\$300	\$1,301
	Level 5	\$500	\$2,007
	Critical Care	\$208	\$528
710XX	Level 3	\$131	\$717
	Level 4	\$257	\$1,326
	Level 5	\$587	\$2,007
	Critical Care	\$318	\$600
711XX	Level 3	\$131	\$717
	Level 4	\$257	\$1,326
	Level 5	\$587	\$2,007
	Critical Care	\$318	\$600

New Hampshire			
ZIP	Visit Severity	FAIR Average	Health Allowables 80th Percentile Charges
030XX	Level 3	\$87	\$284
	Level 4	\$162	\$445
	Level 5	\$223	\$1,323
	Critical Care	\$294	\$837
031XX	Level 3	\$87	\$284
	Level 4	\$162	\$445
	Level 5	\$223	\$1,323
	Critical Care	\$294	\$837
032XX	Level 3	\$106	\$422
	Level 4	\$185	\$590
	Level 5	\$238	\$652
	Critical Care	\$318	\$1,141
033XX	Level 3	\$87	\$284
	Level 4	\$162	\$445
	Level 5	\$223	\$1,323
	Critical Care	\$294	\$837
034XX	Level 3	\$106	\$422
	Level 4	\$185	\$590
	Level 5	\$238	\$652
	Critical Care	\$318	\$1,141
035XX	Level 3	\$106	\$422
	Level 4	\$185	\$590
	Level 5	\$238	\$652
	Critical Care	\$318	\$1,141
036XX	Level 3	\$106	\$422
	Level 4	\$185	\$590
	Level 5	\$238	\$652
	Critical Care	\$318	\$1,141
037XX	Level 3	\$92	\$323
	Level 4	\$168	\$449
	Level 5	\$221	\$590
	Critical Care	\$457	\$1,141
038XX	Level 3	\$93	\$473
	Level 4	\$248	\$1,052
	Level 5	\$417	\$1,648
	Critical Care	\$254	\$731

New York						
ZIP	Visit Severity	FAIR Average	Health Allowables	FAIR Percentile	Health Charges	80th
110XX	Level 3	\$173		\$448		
	Level 4	\$308		\$806		
	Level 5	\$458		\$1,211		
	Critical Care	\$606		\$1,931		
118XX	Level 3	\$172		\$448		
	Level 4	\$308		\$806		
	Level 5	\$456		\$1,211		
	Critical Care	\$639		\$2,000		
121XX	Level 3	\$184		\$543		
	Level 4	\$329		\$946		
	Level 5	\$468		\$1,397		
	Critical Care	\$395		\$1,706		
126XX	Level 3	\$159		\$421		
	Level 4	\$161		\$754		
	Level 5	\$291		\$1,086		
	Critical Care	\$402		\$1,342		
130XX	Level 3	\$169		\$669		
	Level 4	\$157		\$1,269		
	Level 5	\$229		\$1,874		
	Critical Care	\$222		\$585		
136XX	Level 3	\$81		\$398		
	Level 4	\$193		\$707		
	Level 5	\$278		\$1,107		
	Critical Care	\$226		\$771		
137XX	Level 3	\$142		\$574		
	Level 4	\$132		\$346		
	Level 5	\$353		\$1,094		
	Critical Care	\$223		\$643		
142XX	Level 3	\$136		\$431		
	Level 4	\$234		\$635		
	Level 5	\$357		\$1,011		
	Critical Care	\$299		\$1,110		
146XX	Level 3	\$47		\$225		
	Level 4	\$111		\$375		
	Level 5	\$210		\$550		
	Critical Care	\$359		\$870		
149XX	Level 3	\$80		\$669		
	Level 4	\$169		\$1,269		
	Level 5	\$311		\$1,874		
	Critical Care	\$295		\$660		