NORTH CAROLINA MEDICAL SOCIETY

October 30, 2007

The Honorable Jim Long, Commissioner
NC Department of Insurance
PO Box 26387
Raleigh, NC 27611

Re: Aetna's payments to non-participating physicians at 125% of the Medicare fee schedule.

Dear Commissioner Long:

The purpose of this letter is to respectfully request that NCDOI review the following issues:

1. Aetna Non-Participating Payment Policy: As you know, Aetna has a number of benefit plans that cover services of non-participating providers at "out-of-network" levels. Aetna has recently announced on a national basis that it would limit reimbursement of non-participating physicians to 125% of the Medicare rate. We believe from our review of EOBs that Aetna has implemented this payment policy in North Carolina. We would appreciate your validation of that policy change by Aetna, and the number of claims and physicians affected in North Carolina. *(Attachment 1: Letter to Physicians and State of New Jersey Order No. A07-59; Attachment 2: Sample North Carolina EOBs)*

2. Application of North Carolina Statute: We would appreciate your evaluation of whether this policy for non-participating physicians violates NCGS §58-3-190(d) by imposing cost-sharing on patients treated by emergency non-par physicians to a greater extent than would have been imposed if the physicians were participating with Aetna. Similarly, we do not believe that Aetna members have received adequate notification of the policy, or are able to discern the participation status of emergency room physicians in any given hospital in accordance with NCGS §58-3-190(f). Indeed, in sample provider directory searches on the Aetna website, the category of "emergency physician" is not listed at all, although the hospitals with which the physicians are affiliated are listed prominently. *(Attachment 3: NCGS §58-3-190)* The 125% limitation is not indicated in Aetna's summary benefit plan. For example, its Managed Choice

Open Access 1500 Plan indicates that out of network benefits will be paid at "50% after deductible." *(Attachment 4: Managed Care Open Access 1500 Plan)*

3. Aetna Accessibility Requirements: In addition, we believe that previous NCDOI decisions require Aetna to pay non-participating emergency department (ED) physicians (including both emergency room physicians and on-call physicians) at billed charges, thereby holding the patient harmless for services he/she reasonably believes to be necessary. Under this scenario, patients are penalized and subjected to out-of-benefit levels for prudently obtaining emergency care without unreasonable delay. This is a violation of both NCGS §58-3-190 and NCDOI 02-B-6. *(Attachment 5: NCDOI 02-B-6: Applicability of North Carolina General Statute § 58-3-200(d) in the Enforcement of Anti-Assignment Clauses in Insurance Contracts)*

Background: Emergency Departments

Emergency medicine is unique in numerous ways. Emergency Departments have a legal obligation under the Emergency Medical Treatment Act of Labor Act (EMTALA) to provide care and treatment regardless of the patient's ability to pay, insurance status, residency or condition. The financial strain that EMTALA places on the financial viability of emergency rooms is overwhelming. Federal programs implemented to reimburse hospitals for providing care to undocumented immigrants have been ineffective due to identity verification requirements.

While reimbursement levels have significantly declined in the last decade, costs of emergency care have continued to increase, particularly in light of the need to maintain adequate staffing levels to meet the increase in demand for emergency services. Emergency Departments incur tremendous costs in order to provide adequate staffing, particularly in the state's trauma centers. Emergency physicians, emergency nurses, staff and specialists are on call on a 24x7x365 basis. Thus, there is an inherent standby and uncompensated care cost attached to emergency medicine. Allowing entities such as Aetna to impose devastating reimbursement policies such as the one at issue here could result in the collapse of the emergency room safety net. *(Attachment 6: Executive Summary: Hospital-Based Emergency Care: At the Breaking Point, National Academy of Sciences, Institute of Medicine's Committee on the Future of Emergency in the United States Health System)*

The U.S. Department of Health and Human Services Office of the Inspector General (OIG) has clearly stated that Medicare, Medicaid and payments made by other federal insurance programs should not be considered when considering the reasonableness of provider's charges. Likewise, the OIG has stated that discounts offered to uninsured or indigent patients should not be considered in determining the reasonableness of the provider's charges (see *generally* Federal Register 53939, Vol. 68, No. 178 (9/15/03).

Due to the high and growing indigent population served by emergency rooms and numerous other factors, emergency room costs and thus charges greatly exceed the

Medicare Fee Schedule (MFS). This is true whether the fees are set as a multiple of the MFS or based on commercially available products such as Ingenix or The Wasserman Index.

Background: Aetna Policy

In mid-2007, Aetna distributed a letter to providers on a national basis to explain its new reimbursement policy. The letter notified physicians that they would be paid no more than 125% of Medicare rates for services provided by non-participating providers. The clear implication of the letter and related communications is that Aetna intends to drive non-participating physicians into its networks to the detriment of their relationships with physicians, employers and patients. NCMS has received forwarded email communications from Aetna indicating a similar policy has been enacted in North Carolina.

When Aetna is unable reach reasonable contract terms with providers, patients are dramatically impacted. If the health plan pays the patient at less than billed charge rates (as contemplated here) the emergency department physicians are unfortunately forced to bill patients: (1) deductible and coinsurance amounts, (2) Aetna's 125% payment amount (if not paid directly to the provider), and (3) the remainder up to the billed charge amount. Patients are confused by these calculations and transactions, and frequently respond by contacting the emergency department, the health plan, mishandling the funds, or expending the funds elsewhere. A number of patients will end up in collection proceedings, affecting their financial well-being and credit rating. Despite these administrative actions, collection rates are reported at approximately 50%. The remaining costs are then shifted to private self insured employers, other health plans and the general pubic through tax subsidies.

Legal Analysis

NCGS Section 58-3-190(d) reads as follows:

(d) Coverage of emergency services shall be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. An insurer shall not impose cost-sharing for emergency services provided under this section that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the insurer.

The statute recognizes that a patient in need of emergency services should not be expected to drive along the highways to try to determine which of the hospitals or Emergency Departments in those hospitals participate with his or her health plan. It would be misleading and unfair to patients to assure them that their reasonable emergency room care is a covered benefit, then follow up with significant financial responsibility for the care rendered. Provider directories are often unclear whether emergency room physicians participate, even when a hospital is clearly participating. The title of Section 58-3-190: “Coverage required for emergency care,” suggests that the General Assembly believes that fair and reasonable reimbursement should be part of the

health plans obligations in addition to the requirements of the “prudent layperson” standard.

Aetna’s reimbursement policy of 125% of Medicare rates violates NCGS Section 58-3-190(d). Since Emergency Department costs and charges greatly exceed the Medicare rate (as discussed above), it necessarily follows that non-par ED providers will be forced balance bill Aetna members. These patients will then be asked to pay higher cost sharing levels than would have been paid by these patients if the ED providers were in Aetna’s networks—clearly prohibited under the statute. If Aetna patients are not balance billed, other competitor health plan patients, private employers and the uninsured would experience cost shifting and subsidize Aetna for its low payment levels. This is anti-competitive and inequitable.

Likewise, non-participating on-call specialists who respond to the hospital's EMTALA mandate to render professional screening and/or stabilizing care will also be likely to balance bill Aetna members. NCGS 58-3-190(a) applies to “coverage of emergency services” including professional services “to screen and to stabilize . . . .” The General Assembly clearly intended coverage for both ED physicians and on-call specialists who render emergency services. Thus, Aetna’s newly announced policy violates subsection NCGS 190 §58-3(d) for on-call specialists as well as emergency physicians.

As stated previously, we do not believe that Aetna members have received adequate notification of the policy, or are able to discern the participation status of emergency room physicians in any given hospital in accordance with NCGS §58-3-190(f). Sample searches on the Aetna website do not reflect a category of "emergency physician." Hospitals are consistently listed as participating, thus a reasonable assumption by the patient would be that physicians in the emergency department are participating.

The NCDOI statement regarding accessibility to care requires that valid assignments of benefits be honored in those cases where to do otherwise would result in penalties to patients seeking care without reasonable delay. Indeed it is hard to imagine a more severe penalty than patients paying more for services of non-participating providers in this context. Lack of reasonable notice regarding non-participating physicians simply adds to this injustice.

Conclusion

The undersigned respectfully request that the NC DOI conduct a review of Aetna's payment policies of non-participating emergency department physicians, to take all necessary and appropriate action to determine whether Aetna is in violation of the NCGS Chapter 58 and the NCDOI Bulletin, and to craft appropriate remedies. We strongly believe that many of the practices and activities described above will not only penalize the patients and providers, but are contrary to existing North Carolina statutes

which clearly permit a prudent layperson reasonable access to emergency departments without unreasonable delay, and without financial penalties.

Sincerely,

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Robert W. Seligson, Executive Vice President, CEO
The North Carolina Medical Society

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J. Brent Myers, MD, President
North Carolina College of Emergency Physicians

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Rodney L. McCaskill, MD, Vice President
Wake Emergency Physicians, PA

Attachments

ATTACHMENTS

Attachment 1: Letter to Physicians, State of New Jersey Banking and Insurance Department, Order No. A07-59.

Attachment 2: Sample North Carolina EOBs

Attachment 3: §58-3-190. Coverage required for emergency care.

Attachment 4: Managed Choice Open Access 1500 Plan

Attachment 5: NCDOI 02-B-6: Applicability of North Carolina General Statute §58-3-200(d) in the Enforcement of Anti-Assignment Clauses in Insurance Contracts

Attachment 6: Executive Summary: Hospital-Based Emergency Care: At the Breaking Point, National Academy of Sciences, Institute of Medicine's Committee on the Future of Emergency in the United States Health System

ATTACHMENT 1: LETTER TO PHYSICIANS AND STATE OF NEW JERSEY ORDER NO. A07-59

ATTACHMENT 2: SAMPLE NORTH CAROLINA EXPLANATIONS OF BENEFITS (EOBs)

ATTACHMENT 3: § 58-3-190. COVERAGE REQUIRED FOR EMERGENCY CARE.

(a) Every insurer shall provide coverage for emergency services to the extent necessary to screen and to stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(b) With respect to emergency services provided by a health care provider who is not under contract with the insurer, the services shall be covered if:

(1) A prudent layperson acting reasonably would have believed that a delay would worsen the emergency, or

(2) The covered person did not seek services from a provider under contract with the insurer because of circumstances beyond the control of the covered person.

(c) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the provider of the emergency services or the covered person.

(d) Coverage of emergency services shall be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. An insurer shall not impose cost-sharing for emergency services provided under this section that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the insurer.

(e) Both the emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or post-stabilization services in order to avoid material deterioration of the covered person's condition within a reasonable clinical confidence, or with respect to a pregnant woman, to avoid material deterioration of the condition of the unborn child within a reasonable clinical confidence.

(f) Insurers shall provide information to their covered persons on all of the following:

(1) Coverage of emergency medical services.

(2) The appropriate use of emergency services, including the use of the "911" system and other telephone access systems utilized to access pre-hospital emergency services.

(3) Any cost-sharing provisions for emergency medical services.

(4) The process and procedures for obtaining emergency services, so that covered persons are familiar with the location of in-plan emergency departments and with the location and availability of other in-plan settings at which covered persons may receive medical care.

(g) As used in this section, the term:

(1) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including,

but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

(2) "Emergency services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available to the emergency department.

(3) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(4) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(5) "To stabilize" means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of hospitals in emergency

cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred. (1997-443, s. 11A.122; 1997-474, s. 2.)

ATTACHMENT 4: AETNA MANAGED CHOICE OPEN ACCESS 1500 PLAN

ATTACHMENT 5: NCDOI 02-B-6: APPLICABILITY OF NORTH CAROLINA GENERAL STATUTE §58-3-200(D) IN THE ENFORCEMENT OF ANTI-ASSIGNMENT CLAUSES IN INSURANCE CONTRACTS

North Carolina Department of Insurance Jim Long, Commissioner

Bulletin

Number 02-B-6

TO: **Health Maintenance Organizations and Insurers Offering Preferred Provider Benefit Plans**

DATE: June 20, 2002

RE: **APPLICABILITY OF NORTH CAROLINA GENERAL STATUTE § 58-3-200 (d) IN THE ENFORCEMENT OF ANTI-ASSIGNMENT CLAUSES IN INSURANCE CONTRACTS**

This Bulletin sets out the Department's interpretation of North Carolina General Statute § 58-3200(d), as it relates to clauses in insurance contracts prohibiting the assignment of benefits to health care providers who are not under contract with the insurer.

Insurers' preferred provider benefit plans and health maintenance organizations' (HMOs) benefit plans, defined in North Carolina General Statutes §§ 58-50-56, 58-67-5 and 58-3-200, are health benefit plans in which enrollees are given incentives through differentials in deductibles, coinsurance or copayments to obtain covered services from health care providers who are under contract with the plan. Insurers offering network plans are required to maintain provider networks that are sufficiently accessible and available to meet their insureds' health care needs. Participating providers agree to accept payment for services from the health plan, collecting only the applicable deductible, coinsurance or copayment from the insured. Network plans may restrict or limit coverage for health care services obtained from non-participating providers and may include provisions in their insurance contracts prohibiting the assignment of benefits to non-participating providers.

Under North Carolina General Statute § 58-3-200 (d), insurers are prohibited from penalizing or subjecting insureds to out-of-network benefit levels when an insured receives covered services from a non-participating provider *because a participating provider was not reasonably available without unreasonable delay.* The statute refers to the application of penalties in general, as well as to different benefit levels that may be applied when the insured has elected to obtain services from a non-participating provider. Until recently, questions posed to the Department regarding the meaning of § 58-3-200 (d) focused on the insured's liability and insurer payment necessary to satisfy the provision regarding out-of-network benefit levels. Now, insurers and providers have

inquired about the Department's interpretation of penalties other than out-of-network benefit levels.

The clear intent of this statute is to prevent the insured from suffering any monetary or other penalty when services of a participating provider are not reasonably available without unreasonable delay. The enforcement of a non-assignment clause effectively subjects an insured to penalties when it causes the insured to make out-of-pocket payments in excess of the in-network deductible, coinsurance or copayment, while awaiting reimbursement from the insurer. Therefore, the Department has concluded that North Carolina General Statute § 58-3-200 (d) prohibits the enforcement of anti-assignment clauses in insurance contracts in cases where an insured must obtain services from a non-participating provider because a participating provider is not reasonably available without unreasonable delay, and where the enforcement would subject the insured to the penalties described above. Therefore, insurers are required to take steps to prevent insureds from being in the position of having to make payment at the time of service (other than applicable deductibles, copayment or coinsurance) and awaiting reimbursement, in cases where services are rendered by non-network providers because a network provider is not reasonably available without unreasonable delay.

The Department recognizes that some insurers' claims processing systems will require re-programming in order to comply with this directive (e.g. systems currently programmed to automatically generate payment to the insured when a claim is filed by a non-participating provider). In addition, some insurers may elect to modify their claims processing systems in order to facilitate the handling of these claims. Automated claims processing systems, however, cannot be programmed to accurately differentiate every claim for which assignment should be honored in accordance with this Bulletin, and consequently some claims will require investigation or manual processing. Policies and procedures governing both automated and manual claims processing will require the appropriate revisions. Finally, depending upon its current practices, an insurer may find it necessary to modify their policies and procedures with respect to pre-service authorizations, member services, appeals and grievances and perhaps other internal operations, in order to honor assignments as set out in this Bulletin.

Insurers are required to fully implement the operational changes necessary to comply with this directive by **August 23, 2002.** The Department will generally consider an insurer to be in compliance with this directive where it is evident the insurer has made good faith efforts to implement or modify its manual and/or automated claims processing systems, has instituted the appropriate underlying policies and procedures for recognizing valid assignments of benefits in accordance with this Bulletin, and is processing claims accordingly.

Questions regarding this Bulletin should be directed to:
Nancy O'Dowd, Deputy Commissioner
Managed Care and Health Benefits Division
North Carolina Department of Insurance

ATTACHMENT 6: EXECUTIVE SUMMARY: HOSPITAL-BASED EMERGENCY CARE: AT THE BREAKING POINT, NATIONAL ACADEMY OF SCIENCES, INSTITUTE OF MEDICINE'S COMMITTEE ON THE FUTURE OF EMERGENCY IN THE UNITED STATES HEALTH SYSTEM

NORTH CAROLINA DEPARTMENT OF INSURANCE
Jim Long, Commissioner

LIFE AND HEALTH DIVISION
1201 Mail Service Center • Raleigh, NC 27699-1201 • (919)733-5060 • (919)715-3547 (Fax)
AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

January 16, 2008

Mr. Robert W. Seligson, Executive Vice President, CEO
The North Carolina Medical Society
P.O. Box 27167
Raleigh, NC 27611

Re: Aetna Health of the Carolinas, Inc.

Dear Mr. Seligson:

The following is in response to your letter of October 30, 2007 presenting concerns with the manner in which Aetna processes claims for non-contracted emergency service providers, specifically, emergency physicians and is limited to the specifics presented in such letter.

The first point your letter makes is asking for validation that Aetna has implemented a procedural change in North Carolina which limits Aetna reimbursement to non-contracted physicians to 125% of the Medicare rate.

Response: The Department has confirmed that Aetna has implemented a payment process which attempts to settle non-participating physician claims for a service rate of 125% of the Medicare rate. Aetna has determined that level of reimbursement to be a fair and reasonable absent a contract between Aetna and the provider. This process is viewed as a negotiation with the non-contracted provider to help hold down claim costs for the insured member and ultimately that of health care costs in general. As a result of our review of this matter with Aetna, they have instituted a process to issue an explanation of benefits to the insured claimant (which previously was not done for HMO members) and also a separate notice that should the provider seek additional reimbursement above the amount allowed by Aetna, the insured claimant is instructed to contact Aetna for assistance necessary to protect the insured from additional charges. This process appears to comply with the requirements of NCGS §58-3-200(d) and therefore no reason to require a report of the number of claims and physicians affected in North Carolina.

The second concern presented in your letter requested evaluation of whether the process of Aetna's violates NCGS §58-3-190.

Response: Aetna responds that coverage of emergency services is at the in-network level of benefits regardless of participating or non-participating status of the emergency service provider. The cost sharing on emergency service is the same whether provided by participating or non-participating providers. Although hospitals typically are contracted, emergency room physicians, and other emergent care type providers tend

to not agree to contract and for that reason Aetna provider directories, as well as other carriers, are indeed lacking these types of contracted emergency providers. The carrier should have every opportunity to negotiate the service charge while protecting the member from penalty when contracted providers are not reasonably available or accessible. The process as described above in the first concern protects the insured member from penalty for using a non-participating emergency provider.

The third concern presented in your letter presents the question of applicability of North Carolina Department of Insurance Bulletin 02-B-6.

Response: This bulletin is very specific in applicability and does not apply to the situations presented in your letter.

I have enclosed a copy of the response from Aetna to the issues you have presented.

Sincerely,

Ted A. Hamby

Ted A. Hamby, FLMI
Deputy Commissioner
Life and Health Division
Email: thamby@ncdoi.net

C: James P. Wolf, Aetna Regional General Counsel
James E. Long, Commissioner of Insurance

Aetna®

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James P. Wolf
Regional General Counsel
Law and Regulatory Affairs

11675 Great Oaks Way
Alpharetta, GA 30022
Telephone: 770-346-2101
Fax Number: 860-754-1086
Email: Wolfjp@aetna.com

Via Electronic Mail

November 16, 2007

Mr. Ted A. Hamby, FLMI
Deputy Commissioner
Life and Health Division
North Carolina Department of Insurance
1201 Mall Service Center
Raleigh, North Carolina 27699-1201

Re: Emergency Service Reimbursement

Dear Mr. Hamby:

Thank you for your letter of November 7, 2007, providing the opportunity to respond to a letter dated October 30, 2007, from the North Carolina Medical Society.

The North Carolina Medical Society has requested that the Department of Insurance review Aetna's determination to reimburse non-participating providers of (in this case) emergency services at a fair and reasonable rate of reimbursement. We believe that such reimbursement is consistent with the requirements of North Carolina Law, and that the Department will reach this conclusion should it elect to conduct a review.

Background

Aetna takes seriously its duty to maintain access to affordable, high quality health care for our members. One way to keep health care affordable is to ensure that Aetna reimburses providers of emergency services at a fair and reasonable rate of reimbursement when Aetna does not hold a contract with the provider.

Aetna members may obtain emergency services from participating or from non-participating providers. Aetna reimburses non-participating providers who provide emergency services to Aetna's members at a rate which is 25% greater than Medicare's reimbursement for the same service. Aetna considers this as payment in full under the terms of the member's plan, and does not make additional reimbursement unless there is a specific unique circumstance or complexity involving the service provided. In such a case, the provider can submit this additional information to us for further review.

Application of North Carolina General Statutes §58-3-190(d)

Initially, the Medical Society argues that Aetna's payment policy violates §58-3-190(d) "by imposing cost-sharing on patients treated by emergency non-par physicians to a greater extent than would have been imposed if the physicians were participating with Aetna." This is inaccurate.

Aetna's plans provide coverage of emergency services at the in-network level of benefits, regardless of whether the provider is participating or not participating with Aetna. As a result, the cost-sharing (the co-payment, coinsurance or deductible for which a member is responsible under the plan) does not vary depending upon whether the provider of emergency services is in-network or is out-of-network.

We will address below the amount which a non-participating provider is entitled to receive in payment for its services. However, Aetna is not imposing cost-sharing on patients treated by emergency non-par physicians to a greater extent than would have been imposed had the physician been participating. In point of fact, the cost-sharing is the same. As a result, there has been no violation of N.C.G.S. §58-3-190(d).

Application of Bulletin NCDOI 02-B-6

The Medical Society also points to the Department's Bulletin 02-B-6, entitled "Applicability of North Carolina General Statute 58-3-200(d) in the Enforcement of Anti-assignment Clauses in Insurance Contracts." As with the earlier reference to §58-3-190(f), the actions of Aetna in paying a fair and reasonable level of reimbursement to a non-participating provider of emergency services do not violate the guidance provided by the Department in the Bulletin.

The Bulletin sets forth the Department's interpretation of N.C.G.S. §58-3-200(d), as it relates to clauses in insurance contracts that prohibit assignment of benefits. In the Bulletin, the Department states that §58-3-200(d) "prohibits the enforcement of anti-assignment clauses in insurance contracts in cases where an insured must obtain services from a non-participating provider because a participating provider is not reasonably available without unreasonable delay," where the enforcement of such a clause would subject the insured to a monetary or other penalty. In this case, reimbursement has been made by Aetna directly to the non-participating provider, so an anti-assignment clause is not involved. The only issue presented by Aetna's policy is the appropriate level of reimbursement to a non-participating provider of emergency services.

Appropriate Reimbursement to Non-Participating Provider of Emergency Services

Aetna recognizes that providers of emergency services have a legal obligation to determine whether an emergency medical condition exists when an individual presents at an emergency department and to provide services to stabilize that emergency medical condition. It is for that reason that N.C.G.S. §58-3-190 requires that an insurer "provide coverage for emergency services to the extent necessary to screen and stabilize the person covered under the plan." Further, the insurer may not require an authorization of the services if a prudent layperson believes that an emergency medical condition existed. However, §58-3-190 stops short of prescribing the precise level of payment that must be made to the provider of emergency services.

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If the provider of emergency services is participating with the insurer, the amount of payment to which the provider is entitled is set forth in the contract between the provider and the insurer. On the other hand, if the provider is not participating (where there exists no agreement on the level of reimbursement), then North Carolina law provides that the provider is only entitled to recover what the services are reasonably worth. See e.g. Forsyth County Hospital Authority v. Sales, 82 N.C.App. 265, 346 S.E.2d 212 (1986). That amount is not necessarily what the provider chooses to bill for those services.

Aetna calculates its payment to non-participating providers of emergency services at an amount that is 25% more than Medicare would pay for the same service. Aetna believes this is a fair basis for payment because Medicare's payment level is based on the service's resource costs (physician work, practice expense and professional liability insurance) and Aetna then pays a substantial premium over what Medicare would pay. For these reasons, the amount Aetna pays will be fair and reasonable in most cases.

In the event that a non-participating provider of emergency services disagrees with Aetna's determination that it has made a fair and reasonable payment to the provider, the provider has the right to appeal from Aetna's determination and to request that Aetna reconsider its payment to the provider. If the provider can demonstrate that the payment made by Aetna does not constitute a fair and reasonable level of reimbursement for the services provided, Aetna will make additional reimbursement to that provider.

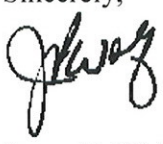
Notification to Members

The Medical Society also complains that Aetna has not provided adequate notification of its reimbursement policy to its members. Aetna agrees that additional information could help avoid possible member confusion. Aetna therefore will send HMO members (who normally do not receive an explanation of benefits) a letter clarifying what members should do if the provider balance bills them in these situations. Aetna will send this letter at the same time it sends its payment to the provider. We are in the process of finalizing this process, which we anticipate will be implemented shortly.

Conclusion

In conclusion, Aetna respectfully submits that its policy for reimbursement to non-participating providers of emergency services to its members provides a fair and reasonable reimbursement and is compliant with North Carolina law. Should the Department have any questions or concerns regarding Aetna's reimbursement policy, Aetna looks forward to the opportunity to answer those questions and to discuss those concerns with the Department.

Sincerely,



James P. Wolf

JPW:cjm

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Dear [Member name]:

Payment was made to [name of physician or physician group], a health care provider that does not participate with Aetna, for services rendered to [insert patient name] on [insert date]. Under the terms of your plan, the services from this provider were considered as an in-network (referred) benefit. Please note that we do not have a contract with this provider, and the provider may not accept Aetna's payment as payment in full for these services.

Aetna seeks to ensure that you do not pay this provider any amount above any applicable copayment, coinsurance or deductible at your in-network (referred) benefit level. If this provider bills you, please send us the bill and include a copy of this letter at the address listed on the back of your member ID card for us to handle. Include your member ID number with the bill to assist us in the timely processing of your bill.

If you have any questions, please contact our Member Services Department at the number located on the back of your ID card.

Sincerely,