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December 20, 2007

Robert J. Greczyn, Jr.
President and Chief Executive Officer
Blue Cross and Blue Shield of North Carolina
P.O. Box 2291
Durham, NC 27702

Dear Mr. Greczyn, Jr.:

I am writing with respect to your company's practice of requiring higher patient cost-sharing for select endoscopy and colonoscopy procedures in a facility setting. For the reasons set forth below, we believe that this policy threatens patient access to life-saving colorectal screenings and other medically necessary GI procedures for your enrollee population.

1. INTRODUCTION

The American College of Gastroenterology is a physician organization representing gastroenterologists and other gastrointestinal specialists. Founded in 1932, the College currently numbers more than 10,000 physicians among its membership of health care providers of gastroenterology specialty care. Although the vast majority of these physicians are gastroenterologists, the College's membership also includes surgeons, pathologists, hepatologists, and other specialists in various aspects of the overall treatment of digestive diseases and conditions. The College has chosen to focus its activities on clinical gastroenterology – the issues confronting the gastrointestinal specialist in treatment of patients. The primary activities of the College have been, and continue to be, educational efforts directed at promoting and optimizing quality care.

We have been alerted by concerned North Carolina providers in your network of enrollees who have been subject to extremely high coinsurance and deductibles because they have had colonoscopy/endoscopy procedures performed in hospital outpatient facilities. Requiring higher cost-sharing in this setting creates financial barriers to access to care. In certain North Carolina counties, according to our members, none of these procedures are performed in physicians' offices. Indeed, well over 90% of gastrointestinal procedural services are provided in the hospital outpatient department or ambulatory surgery centers. Recent literature confirms the preference for facilities which meet Medicare certification criteria.

Given that colon cancer is the number two cancer killer in the U.S. and North Carolina, it seems counterproductive to create barriers to patient access to CRC screening. Most literature reviews have found colonoscopy to be cost effective as well. Therefore, it seems counterproductive to create cost-sharing policies that discourage its appropriate utilization in the setting that the individual physician and patient feel is the safest and most appropriate given the patient's needs and the procedure's complexity.

While we do not have all the details about the manner in which you are employing your policies and practices, what we do know is troubling. Other jurisdictions have employed site-of-service differentials for physician payment, which we have also vociferously objected to. Upon subsequent review, however, some jurisdictions have reversed these policies. Moreover, recent literature underscores significant problems with this site-of-service approach. Site-of-service payment differentials create false incentives for physicians to perform procedures in the unregulated office setting as the same physician work is done no matter what setting is used.

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This same approach was adopted by Medicare beginning in 1997. Despite the financial incentive, it is to the credit of gastrointestinal specialists that the percentage of Medicare GI services performed in the hospital outpatient department (HOPD) or ambulatory service center (ASC), as noted previously, is well over 90%, even though they are being offered a much larger fee if they would move to the office setting. It is important to recognize that the reason for this strong preference for the ASC and HOPD is that performing these services in a facility that meets Medicare guidelines provides the best assurances of safety for patients and for preventing any complications. Even within the small subset of 5% or so of Medicare procedures which are recorded in the office or office setting, a substantial number of these are facilities in states which have certificate of need (CON) problems, and the facilities nonetheless meet the Medicare certification criteria even though not formally certified as an ambulatory service center.

Performance of procedures involving sedation and potential complications for such GI endoscopies needs to be accomplished in the setting and by the provider that offers the best protections and strongest assurances for patients. Your adoption of this site-of-service coinsurance approach is directly contrary to the best interests of those patients and subscribers. Your subscribers are not well-served by creating false economic incentives which may interfere with appropriate considerations for correct choice of location of procedural services they receive or the providers they use. These policies make even less sense when the enrollees have no choice of setting because the procedures are only offered in a facility setting.

According to the CDC, in 2004, only 57.7 percent of North Carolinians aged 50 and over have had any screening for colon cancer. Fewer still have had screening colonoscopy, the “gold standard” screening test. These numbers are clear evidence of under-utilization of a known effective procedure. Your policies and practices regarding coinsurance site-of-service differentials will only exacerbate this quality problem.

We are enclosing and call to your attention the September 2003 article from *Archives of Surgery* detailing the experience in Florida with potential health risks and comparisons of Medicare certified vs. non-certified facilities. This study concludes that: “In this review of surgical procedures performed in offices and ambulatory surgery centers in Florida during a recent 2-year period, there was an approximate ten-fold increased risk of adverse incidents and death in the office setting. If all office procedures had been performed in ambulatory surgery centers, approximately 43 injuries and six deaths per year could have been prevented.” So, again this study serves to demonstrate that the site-of-service approach –whether for physician payment of beneficiary coinsurance -- is contrary to the best interests of your subscribers.

Other authorities have underscored the shortcomings of the site-of-service approach in GI endoscopy.

The Medicare Payment Advisory Committee (MEDPAC) has consistently underscored in its annual reports that the site-of-service policy for GI procedures is inappropriate. The site-of-service approach has also come under scrutiny from Congress.

Conclusion

On behalf of gastrointestinal patients, the College's physicians nationwide, and our members in clinical practice in North Carolina and the patients that they serve, we are advising you that utilizing this site-of-service coinsurance policy is detrimental to the best interests of our patients, increasing both the risks that the choice of location for their service may be made on economic rather than of quality of care rationale and that non-certified, unregulated facilities or under-trained providers who are not subject to monitoring and review in a private office setting may compromise health interests along the lines outlined in the *Archives of Surgery* article.

We believe that continuing to employ this policy threatens the access of your subscribers to essential GI endoscopy procedures, including colorectal screening. Continuing with this site-of service coinsurance differential policy, having been advised of the broad-based concerns about this policy's potential negative impact on patients, creates risks and responsibilities upon your company for any untoward results. We urge you, therefore, to change your policies so that the choice of appropriate setting is made by the physician and the patient on the basis of medical considerations and patient needs and is not dictated by significant and unwarranted coinsurance differentials. Such a policy change is even more important when there is no non-facility site where such services are offered.

Very truly yours,



Amy Foxx-Orenstein, D.O, FACG
President



John Baillie, M.B., Ch.B., FACG
North Carolina Governor, ACG

cc: ACG Board of Trustees
ACG member physicians in North Carolina
Bradley C. Stillman, Executive Director