American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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Making Every Moment Count

April 2, 2019

The Honorable Frederica S. Wilson
Chairwoman
Subcommittee on Health, Employment, Labor, and Pensions
House Committee on Education and Labor
Washington, D.C. 20515

The Honorable Tim Walberg
Ranking Member
Subcommittee on Health, Employment, Labor, and Pensions
House Committee on Education and Labor
Washington, D.C. 20515

Dear Chairwoman Wilson and Ranking Member Walberg:

On behalf of the American College of Emergency Physicians (ACEP) and our 38,000 members, thank you for your efforts to protect patients and their families from unexpected high medical bills. ACEP remains committed to the goal of improving price transparency for our patients in a constructive and substantive manner, and we appreciate your leadership in holding this timely hearing.

Patients cannot choose where or when they will need emergency care, and they should not be punished financially for having emergencies. ACEP strongly agrees that patients must truly be taken out of the middle of billing issues that can arise around insurance coverage of emergency care.

As you examine this important issue, we urge you to keep in mind the particular factors that are unique to emergency medicine. In the emergency department, minutes and seconds matter and emergency physicians are often required to exercise their best clinical judgement quickly. Additionally, emergency physicians and their practice of medicine are subject to the Emergency Medical Treatment and Labor Act (EMTALA) that guarantees access to emergency medical care for everyone, regardless of insurance status or ability to pay. This law – an important consumer protection – has had the effect of disincentivizing health plans from entering into fair and reasonable contracts to provide services at appropriate in-network rates.

Because emergency physicians are required to screen and stabilize any patient who comes into the emergency department (under EMTALA), insurance companies are ensured their policyholders are always able to access emergency care. Therefore, they have no real incentive beyond what are often poorly defined and enforced state requirements to maintain an adequate number of emergency physicians in their networks. They 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 (as permitted under section 2719A of the Affordable Care Act), which then shifts the majority (if not the entirety) of the cost of the encounter to be paid out of the patient's pocket, rather than the insurer's.

Many of the so-called "surprise bills" that patients face following an emergency encounter actually turn out to simply be due to a surprise lack of coverage – where patients discover that the costly insurance premiums they have dutifully paid each month have in actuality provided them with little to no protection against the cost of care due to high deductibles and other opaque or complicated health plan designs.

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As Congress begins developing potential legislative solutions to take the patient out of the middle and eliminate balance billing practices, we believe there are successful, comprehensive policy solutions already in effect in certain states that would be informative to any federal approach. In particular, we believe the examples of New York and Connecticut provide a solid foundation for federal legislation. Brief summaries of these laws are provided in the following pages.

We agree strongly 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. To this end, earlier this year ACEP released a proposed framework of policy solutions to protect emergency patients. Our detailed framework is also included in the following pages, but there are six key provisions:

1) **Balance billing is prohibited** — When a patient receives out-of-network emergency care, the emergency services provider cannot make any demand for such payment from the patient.

2) **Streamline the process to ensure patients only have a single point of contact for emergency medical billing and payment —** Under ACEP's proposal, insurers will directly pay any coinsurance, copay, and deductible for emergency care to the provider, and can then collect back these amounts from the patient. This will put an end to patients receiving and having to reconcile the multiple, confusing bills and explanations of benefits that result from the many providers who often need to be involved in a single emergency episode.

3) **Ensure the patient responsibility portion for out-of-network emergency care is no higher than it would be in-network —** When facing an emergency, patients or their family members do not have time to try and figure out where their care will be in-network, so they should not be punished financially for being unable to do so. Under current law, while copays and coinsurance must be the same for emergency patients whether they are in- or out-of-network, deductibles can be much higher—often double.

4) **Require insurers to more clearly convey beneficiary plan details** — This would include printing the deductible on each insurance card. While a simple step, it can help patients better understand the limits of their insurance coverage and reduce the surprise when they later get a bill.

5) **Require insurers to more clearly explain their rights related to emergency care** — Policyholders deserve to have this in plain, easy-to-understand clear language.

6) **Take the Patient Out of Insurer-Provider Billing Disputes** — ACEP wants to prevent provider/insurer billing disputes. To expedite and simplify this process, ACEP is calling for the creation of an arbitration process to settle network issues, similar to that used in New York (as described in the following pages).

ACEP believes these core principles are necessary first and foremost to protect patients seeking emergency medical care. Additionally, they provide an outline for a policy solution we believe that is not overly burdensome or costly to implement at the federal level, is based on models that have already proven successful at the state level and have not led to inflated costs in those states, and would establish a system that ensures fair and equitable negotiation between providers and insurers.

We also note our strong concerns with proposals that would either provide a single bundled payment from a hospital for emergency services or would set a benchmark payment at a certain level of Medicare rates. A bundled payment would not actually address the underlying cost issues, but instead merely shift the venue for negotiation under the assumption that hospitals would somehow be able to better negotiate with physicians than insurers. With regard to proposals based on a percentage of Medicare rates, this approach is flawed in that 1) Medicare rates were never intended to reflect market rates and have not kept pace with inflation; 2) according to CMS' own actuaries, Medicare rates are not expected to keep pace with the average rate of physician cost increases[1]; 3) Medicare rates were never designed for the general population but rather an age-specific group (e.g., does not include pediatrics or obstetrics); and, 4) Medicare is shifting toward a value-based payment approach, and it is unclear how it could even be used as a basis for determining a benchmark rate in future years.

Once again, ACEP thanks you for your leadership on this effort to protect patients from unexpected medical bills. We appreciate the opportunity to provide these comments, and we stand ready to work with you to develop meaningful reforms.

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[1] 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2018.pdf

Should you have any questions, please do not hesitate to contact Laura Wooster, ACEP's Associate Executive Director of Public Affairs, at lwooster@acep.org.

Sincerely,

Vidor Friedman, MD, FACEP
ACEP President

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Framework for Protecting Patients When Emergency Care is Out-of-Network

By oath and by law, emergency physicians will treat any patient, regardless of their ability to pay. Federal law under the Emergency Medicine Treatment and Labor Act (EMTALA) forbids emergency care providers from discussing with the patient any potential costs of care or details of their particular insurance coverage until they are screened and stabilized. Patients can't choose where and when they will need emergency care – so they should not be punished financially for having emergencies.

Expanded Patient Protections that Truly Take the Patient Out of the Middle

- Balance billing is prohibited -- when a patient receives out-of-network emergency care, the emergency services provider cannot make any demand for such payment from the patient;
- The patient won't pay any more out-of-pocket (i.e. coinsurance, copay, **and** deductible) than they would have paid if their emergency care were in-network (currently such protection only applies to coinsurance and co-pays);
- Insurers will directly pay any coinsurance, copay, and deductible for emergency care to the provider.
    - Insurers can then collect back these amounts from the patient. This ensures patients only have **a single point of contact** for emergency medical billing and payment, and will no longer receive and have to reconcile multiple, confusing bills and EOBs that result from the many providers that are often involved in a single emergency episode.
- To ensure policyholders better understand the limits of their insurance coverage and *all* potential out-of-pocket costs when seeking care, insurers will be required to display the patient's deductible amount on policyholders' insurance cards.
- Insurers must provide their policyholders with clear, concise and meaningful explanations of their plans' emergency services benefits, an up-to-date list of in- and out-of-network providers, and beneficiary rights under EMTALA.

Take the Patient Out of Insurer-Provider Billing Disputes

- The insurer will pay directly to the emergency care provider within 30 days the amount of the deductible and cost-sharing (plus an additional amount as determined below). When provider-insurer disputes arise over reimbursement for out-of-network emergency services, the following will be used to resolve them:
    - The payment amount will be determined under any state law that takes a comparable approach to this proposal.;
    - For claims under $750 (amount to be adjusted for inflation), the balance will be paid in full. For inflation-adjusted amounts over $750, the insurer will pay an interim payment directly to the provider.
- Required payments will be made within 30 days of claim submission. Failure to do so will trigger civil monetary penalties (CMPs) of $500 per day.

Either party may trigger the alternative dispute resolution (ADR) process described below within 30 days of the provider receiving the interim payment.

Alternative Dispute Resolution (ADR)

- HHS will maintain a database of ADR entities that meet certain qualifications (e.g. freedom from conflicts of interest, reasonable fees) to resolve disputes. Costs related to this will be offset by any collected CMPs, as referenced above. HHS may delegate responsibility of the database to a third party such as the American Arbitration Association or to any state that already undertakes a similar function.
- The emergency care provider and insurer will submit to the arbitrator the amount that was charged or billed for the emergency medical services, and the interim amount paid, respectively. Either party may consolidate multiple disputed claims between them into a single adjudication.
- The arbitrator will select one of these two amounts as the payment amount, and in doing so consider the following:
    - The provider's level of skill, education and training,
    - The nature of the services provided,
    - The circumstances and complexity of the case,
    - 80th percentile of charges for comparable services in the same geographical area, as determined by a transparent and wholly independent Medical Claims Database (such as FAIR Health),
    - 150% of the average in-network rate for comparable services in the same geographical area as determined by a transparent and wholly independent Medical Claims Database (such as FAIR Health)
- Arbitration will be completed within 30 calendar days of either party commencing the ADR process. Any payment owed by one party to the other must be made within 15 calendar days of a determination. The costs of the ADR shall be borne by the non-prevailing party.

Commission on Access to Quality and Affordable Emergency Care

HHS will establish a Commission on Access to Quality and Affordable Emergency Care with diverse, cross-sector representation to study and provide recommendations to Congress within three years of bill enactment on specified matters including:

- Adequacy of patient protections, including network adequacy standards and clarity of enrollee notification language from insurers
- If the bill's new processes surrounding out-of-network emergency care are providing sufficient provider protections to ensure continued access to high-quality emergency care for patients;
- The merits of establishing supplemental funding for uncompensated care incurred by emergency physicians pursuant to their practice of medicine under the requirements of EMTALA.

State Models: 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 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 (out of an estimated 7-8 million emergency visits statewide). 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.[2] Similarly, studies have shown that the law has lowered the rate of out-of-network bills by 34 percent and lowered in-network emergency physician payments by 9 percent.

[2] Kaiser Family Foundation (2015-2019): "Marketplace Average Benchmark Premiums," https://www.kff.org/e4f94bd/

State Models: 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.[3] 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. And similarly to the experience in New York, data shows that premiums grew more slowly in Connecticut than the rest of the nation.

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. **ACEP supports a change in federal law that would level deductibles for out-of-network and in-network emergency services**.

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