

Statement of

Vidor E. Friedman, M.D., F.A.C.E.P.

President
American College of Emergency Physicians (ACEP)

Attending Emergency Physician
Florida Hospitals Celebration Health
Orlando, FL

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I. Introduction

Thank you Mr. Chairman and members of the Health Subcommittee. On behalf of the American College of Emergency Physicians (ACEP), our 38,000 emergency physician members, and the more than 150 million Americans we treat on an annual basis, I would like to thank you for this opportunity to testify before your committee today on the issue of surprise medical bills.

In a medical emergency, getting treatment as soon as possible is the number one priority – not verifying which providers are in-network, figuring out how much your deductible is, or worrying how much treatment will cost. These are important considerations to be sure, but the reason my colleagues and I do what we do for a living is, first and foremost, to take care of our patients. Responsibility for their well-being is our top priority, but there are aspects of what we do that make us unique, and this sometimes causes frustration when a patient receives a bill for services rendered that they thought would be covered by their insurance.

Unlike most physicians, emergency physicians are *prohibited by law* from discussing with a patient any potential costs of care or insurance details until they are screened and stabilized. This important patient protection enacted in 1986 under the Emergency Medical Treatment and Labor Act (EMTALA) ensures emergency care focuses on immediate medical needs. However, it also means that patients often do not fully understand the potential costs that could be involved in their care or the limitations of their insurance coverage until they receive their bill.

ACEP, and most of the groups represented at this table and around the room today have been working with lawmakers on this issue for nearly a year. The early discussions focused more on

education about how the system currently operates, what Congress could and should do to address this important issue, and evaluating what states have already enacted. As these discussions progressed and we began to see the initial proposals from various Members of Congress, ACEP announced and put forward a framework of the three key principles that Congress should consider as earlier proposals were refined and new ones introduced:

Protect Patients – Take patients out of the middle of billing disputes. Establish caps on patient responsibility for unanticipated emergency medical care so that patients won't pay more out-of-pocket (i.e., co-insurance, co-pay, *and* deductible) than they would have paid if their emergency care were provided in-network. This is an important distinction because these protections currently only apply to co-insurance and co-payment amounts.

Level the Playing Field – ACEP would strongly urge Congress to limit the scope of their proposal as much as possible to avoid unintentionally providing an advantage to one party over another when there is a disputed claim for out-of-network care, provided the patient has already been removed from such discussions as I previously mentioned. For this reason, we would urge the committee to reconsider using an independent, “baseball-style” arbitration process. This process is a simple, efficient solution that incentivizes providers to charge reasonable rates and insurers to compensate at reasonable rates. For example, in New York, where this process was enacted in 2014 and which became effective in January 2015, this model has almost eliminated surprise medical bills. Meanwhile, insurance premiums and health care costs in the state have grown more slowly than the rest of the nation. This model would be the least disruptive to the current system

and is the only one with empirical data detailing the positive impact it has had for patients and stakeholders alike.

Improve Transparency – To ensure patients better understand the limitations of their insurance coverage and all potential out-of-pocket costs each time they seek care, insurers should more clearly convey beneficiary plan details to their customers. This should include printing the deductible on each insurance card; clearly explaining their rights related to emergency care in easy-to-understand, clear language; and maintaining up-to-date lists of in- and out-of-network providers that are easily accessible.

ACEP appreciates the work the committee members and their staffs have already done to protect patients and their families from unexpected medical bills. It is my sincere hope that my testimony will further help you understand the complexities of this issue, which are not readily apparent upon first glance, as well as illustrate the intended and possible unintended consequences of various surprise medical bill legislative proposals. We all have the same objective: protect patients and ensure their continued access to all types of physicians and specialists so they can get the care they need and deserve.

II. What is EMTALA and What Does it Do?

Essentially, the Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires anyone coming to a hospital emergency department to be stabilized and treated, regardless of their insurance status or ability to pay.

In 1986, EMTALA went into effect as part of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985. It was designed to prevent hospitals from transferring uninsured or underinsured patients to public hospitals without, at a minimum, providing a medical screening examination (MSE) to ensure they were stable for transfer, and if needed, stabilization care. There are three main obligations associated with this law:

1. For any person who comes to a hospital emergency department, there is an affirmative obligation on the part of the hospital and its physicians to provide that patient with an MSE to determine whether an emergency medical condition (EMC) exists.
2. If an EMC exists, the hospital (through the services of emergency and other on-call physicians from other specialties) must stabilize the medical condition provided within its facility or initiate an appropriate transfer to a facility capable of treating the patient. Hospitals are required to maintain a list of these on-call physicians who can provide the treatment needed to stabilize an EMC.
3. Hospitals with more specialized capabilities are obligated to accept appropriate transfers from hospitals that lack the capability to treat unstable EMCs.

While EMTALA only applies to hospitals that participate in the Medicare program, in practical terms, this means that it applies to virtually all hospitals in the United States and the obligations associated with EMTALA apply to all patients, not just to Medicare patients.

Under the EMTALA statute (42 U.S.C. 1395dd) an EMC is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part, or
4. With respect to a pregnant woman who is having contractions, that there is inadequate time to effect the safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or her unborn child.

As is the case with the term EMC, the EMTALA statute defines when a patient is “stabilized,” but this determination is ultimately a matter of clinical judgment on the part of the medical professional assessing the patient.

Violations of EMTALA can subject the hospital and/or physician to a fine of up to \$104,826 per violation (hospital over 100 beds) and up to \$52,414 per violation (under 100 beds).

III. How Does EMTALA Affect Physician-Insurer Contracts

EMTALA ensures that emergency departments, emergency physicians, and other on-call specialists have a “safety-net” of care so that anyone in the nation which requires emergency medical treatment will receive it. However, because the federal government mandates that these services be provided, regardless of insurance status or ability to pay, it means two things. First, the

services rendered by the hospital and its providers often go unreimbursed. Second, because insurance companies know their beneficiaries will receive care in the emergency department regardless of whether the company has a contract for these services or not, there is less incentive for insurers/plans to negotiate for these services and bring emergency physicians in-network.

This, unfortunately, means the claims of physicians who provide emergency care for commercially insured services are often paid by health plans at rates that are substantially below the usual and customary value of these services. In the recent past, most plans based the allowed benefit for these services on the 70th or 80th percentile of usual and customary charges. But, as was the case with Ingenix in New York¹², the database used for this purpose underrepresented these charges. In response to successful legal challenges to such flawed databases, some insurers/plans have established out-of-network benefit rates that are still substantially below usual and customary payments.

The lack of a system to ensure fair benefit reimbursements has allowed insurers/plans to underpay the fair value of emergency services, which has created an imperative to preserve balance billing, or at the very least establish a corresponding fair and independent mechanism to resolve provider-insurer reimbursement disputes. This is vital to ensuring the financial viability of the nation's emergency care system. If an emergency department cannot keep its doors open, then the

¹ <https://www.lexisnexis.com/legalnewsroom/insurance/b/medicalinsurance/posts/final-approval-granted-in-350-million-settlement-with-united-in-reimbursement-dispute>

² <https://www.nytimes.com/2009/01/17/opinion/17sat1.html>

community it serves loses access to these lifesaving services, and that affects the insured and uninsured equally.

IV. Improving Transparency for Consumers

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. As noted earlier, emergency physicians and hospitals are prohibited under EMTALA 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 or the limitations of their particular insurance coverage until they get the bill.

Often any bill following emergency care is, therefore, 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. ACEP proposes insurers be required to include the policyholder's in- and out-of-network deductibles for 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 or other care.

Plans or issuers must specify their insurance product on the patient's member ID card so that it is clear to both the patient and treating providers. For scheduled care, this information can greatly facilitate providers being able to assist patients at the point of care with navigating their coverage

and benefits and more specifically provide out-of-pocket pricing estimates. As well, for both emergency and scheduled care, having this information recorded in a patient's record can help the provider resolve billing issues and potential disputes on the patient's behalf, keeping the patient out of the middle.

Furthermore, plans or issuers must provide their enrollees with meaningful and simple explanations regarding coverage for emergency care that they are guaranteed under federal law. This includes informing them of the federal Prudent Layperson Standard, which requires coverage for patients who seek emergency care for "acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- (i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- (ii) Serious impairment to bodily functions.
- (iii) Serious dysfunction of any bodily organ or part."

While this requirement is in federal law for all commercial plan types, over the past year insurers such as Anthem, United, and Blue Cross Blue Shield of Texas have all implemented policies that to varying degrees can retroactively deny a range of emergency care for policyholders who seek it for symptoms that turn out to be non-emergent.

ACEP is particularly concerned about the lack of transparency around out-of-network rates for services. ACEP has pushed for years to have these rates be determined through a transparent process, using publicly verifiable data. However, regulators have allowed a lack of enforceable

and transparent standards for out-of-network benefits in legislation and regulations governing health plan coverage for emergency care services. Many insurers use the usual, customary, and reasonable (“UCR”) amount to determine their out-of-network rates. We strongly believe that when determining UCR insurers should use a database of geographically comparable usual and customary charges maintained by an independent non-profit organization that is not affiliated, financially supported, and/or otherwise supported by an issuer or by a supplier. This type of database, such as FAIR Health as one example, should be transparent, statistically valid, and protected against conflict of interest.

V. Ensuring Network Adequacy

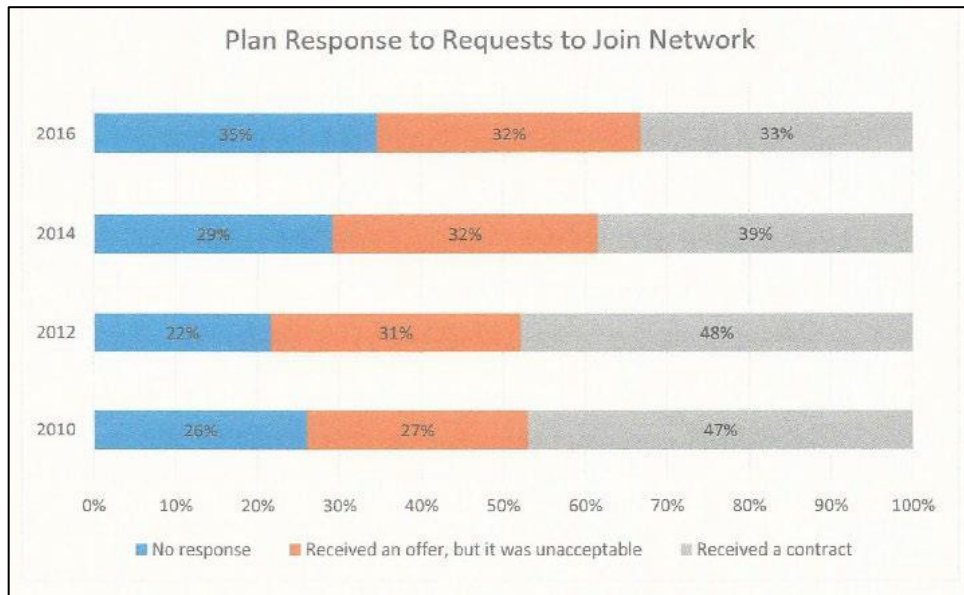
In many parts of the country, insurers have near-monopolies (if not full monopolies) of market share; there are numerous examples of a single plan controlling more than half of the market. Such market power allows insurers to offer take-it-or-leave-it contracts and narrow their physician networks, which just further exacerbates issues of out-of-network care and the unexpected bills that can sometimes result. In fact, according to the Kaiser Family Foundation, the top three insurers in the large group market had a market share of at least 80 percent in 43 states in 2017.³

Emergency physicians *want* to contract with insurers and provide in-network care. Physicians accept low-discounted contract rates with private payors because being in-network provides long-term certainty of a contract, allows for better projections of future business needs, and provides additional assurance of reimbursement directly from the insurer, rather than shifting the responsibility so that physicians must seek it from patients following their care. While all

³ <https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market>

physicians enjoy benefits from being in-network, this last point is especially relevant to emergency physicians. Unlike many physicians of other specialties who practice in the community and can collect patient payment up-front before the patient is even allowed into a treatment room, EMTALA forbids emergency physicians from such practices.

While many states (and even federal law under the Affordable Care Act) require insurers to have adequate networks, these standards are vague, qualitative, and not being enforced. For example, 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 2012.⁴



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

⁴ Texas Medical Association, “Survey of Texas Physician 2016: Research Findings,” available at: https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/2016_Physician_Survey_Findings.pdf

insurance plan but found it unacceptable (i.e., turned it down) remained stable. From this, we can conclude 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.

Similarly, in California, there are numerous reports of insurers refusing to renew long-standing contracts (that paid more than the benchmarked under law out-of-network rate of 125% of Medicare). Some insurers are terminating contracts unless physicians accept payment reductions as substantial as *forty percent*. Other payors are reportedly closing their networks to new physicians, and most are reducing their physician networks overall to eliminate historical contracted rates from the industry benchmarking database to avoid having them serve as a basis for establishing the state contracted rates in the future. And overall, California premiums continue to rise.

At a minimum, Congress should seek to establish a federal patient emergency care access standard and ensure a corresponding enforcement mechanism. This would require health plans or issuers of all commercial products (including ERISA) to demonstrate to their State Insurance Commissioner that their plans ensure patient access to emergency care for an emergency medical condition. The standard should include consideration of time, distance, and provider capacity within the relevant geographic area, and an endeavor to support such access through good faith, comprehensive efforts to contract with emergency treatment providers at reasonable/adequate rates and under timely payment terms.

Therefore, we ask the committee to include specific language in any legislation considered that insurers be required to maintain adequate provider networks. The legislation should require the Secretary of Labor, in consultation with the Secretary of Health and Human Services, to adopt quantitative standards that insurers must meet in order to ensure access to a sufficient number of contracted physicians (specialists, subspecialists, and primary care) and other health care providers in each geographic region who have the requisite training and expertise to provide that care, and in sufficient numbers, so patients may obtain timely access to all necessary medical care from in-network providers when possible.

Special consideration should be given to hospital-based physicians who provide emergency medical care under the federal EMTALA mandate as they cannot refuse treatment of any patient who presents themselves to the hospital emergency department. Without such consideration, insurers would have no incentive to contract with these providers. Additionally, the network adequacy standard must be approved by the Secretaries of Labor and Health and Human Services before each plan may be offered in the market.

VI. Developing an All-Payer Claims Database

ACEP supports the development of robust all-payer claims databases (APCDs) that mandate the collection of claims from all payers. While this may provide informative data for research purposes, if the APCD is used to calculate out-of-network reimbursement rates, then only data derived from commercial plans should be used for that purpose. Fifteen states have APCDs in place, and numerous others are either considering or in the process of, implementing APCDs. States can mandate the submission of some data by state law, resulting in consistent, uniform data.

In all, there are examples of strong state APCDs that collect claims data from all payers, such as Oregon, and others that are not as robust and only collect some data from those payers that voluntarily participate. Virginia's APCD falls in the latter category; although it collects claims from almost every payer, it does not mandate collections, so insurers can pick and choose what data to submit and thus leave room for data manipulation. See Appendix B⁵ of a report prepared by the University of Chicago's NORC for a summary of APCD features by the state as of May 2017.

However, per the U.S. Supreme Court's ruling in *Gobeille v. Liberty Mutual Insurance Co.*, the Court held that states may not require plans regulated under the Employee Retirement Income Security Act (ERISA) to submit their data to the state's APCD (though such data may still be submitted voluntarily). Given that ERISA plans can represent more than 50 percent of employer-sponsored coverage in many parts of the country, APCDs in such states will have limited data that is not representative of the entire population.

As the House Energy and Commerce Committee considers creating a grant program to fund state efforts to implement new, or maintain existing, APCDs, the committee should specify certain criteria for APCDs that states must agree to adhere to to receive the funding. **States that are awarded the grants to develop new APCDs must, on condition of receiving the grant, mandate participation from all payers, including ERISA plans.** The current discussion draft released by the committee does not include any such requirements or even provide guidance for states to consider when implementing new APCDs or maintaining existing APCDs. Furthermore,

⁵ <https://endinsurancegap.org/wp-content/uploads/2017/01/NORC-Revised-Final-5-24-17-2.pdf>

the draft does not specify the purposes for which states can use the APCDs developed using the grant funding, which would impact how the state decides to structure the APCD. If a state's APCD is used for the eventual purposes of creating an established payment amount that would be paid to out-of-network providers (as allowed under the discussion draft's newly added Section 2719A(b)(2)(H)(i) of the Public Health Service Act), it is even more important for the APCD to include claims data from all payers so that the payment amount determined by the state is accurate and not biased. **In short, any federal legislation that mandates the use of a state APCD as a transparent database from which to benchmark out-of-network payments must also provide a corresponding federal requirement that ERISA plans contribute data to it as well.**

An additional technical issue with the current discussion draft relates to the appropriations language. The Committee should clarify that the \$50 million appropriations must be used solely for the actual grants to states. By stating that the appropriation would be used to "carry out this subsection," the Secretary of the Department of Health and Human Services (HHS) could use some of the funding for administrative purposes to establish the grants. Furthermore, the discussion draft should include a deadline by which the HHS Secretary would be required to make the grants to states, or at least issue the funding opportunity announcement. This would ensure that grants are awarded to states in a timely manner.

We believe the changes highlighted above will strengthen the current section in the discussion draft on APCDs and ensure that the grants are used effectively to create APCDs that contain accurate data that is representative of the entire state population.

VII. Using a Benchmark Rate to Determine Reimbursement Disputes

ACEP has previously stated that payment disputes that can sometimes arise between insurers and out-of-network providers should be resolved in a manner that takes the patient completely out of the middle, is transparent, and does not increase federal healthcare expenditures. However, we have strong concerns and oppose the use of a benchmark for establishing out-of-network (OON) payment amounts. We noted previously that emergency physicians want to contract with insurers and accept low-discounted contract rates with private payors in exchange for certain benefits – such as business certainty, reduced administrative burdens, and more efficient reimbursement.

Allowing insurers to access a discounted contract rate (via benchmarked OON payments) without providing the benefits of contracting in exchange will discourage contracting and result in narrower networks of physicians and less patient choice. Discounted OON payments will severely harm emergency physician’s ability to cover even just their practice costs and serve patients, given the additional challenges they face as safety-net physicians who must absorb significant amounts of under- and uncompensated care as a result of the EMTALA mandate.

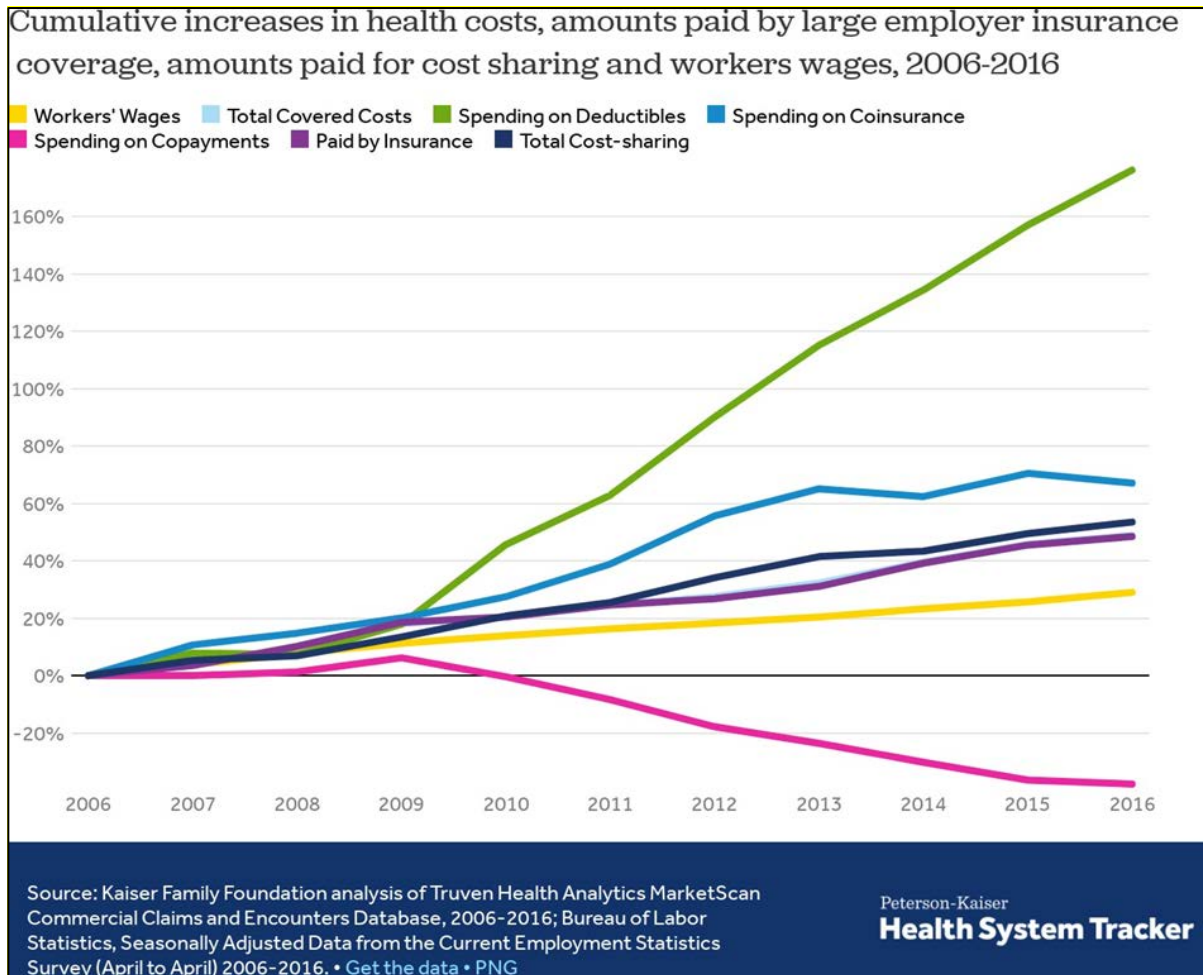
Insurance design changes in recent years have raised deductibles to amounts far beyond what the average American can pay. As noted recently by the Kaiser Family Foundation⁶ (emphasis added),

“...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**

⁶ <https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/#item-start>

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 the graph below) has resulted in a corresponding increase in the amount of bad debt that emergency physicians incur.



Accompanied by 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 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.

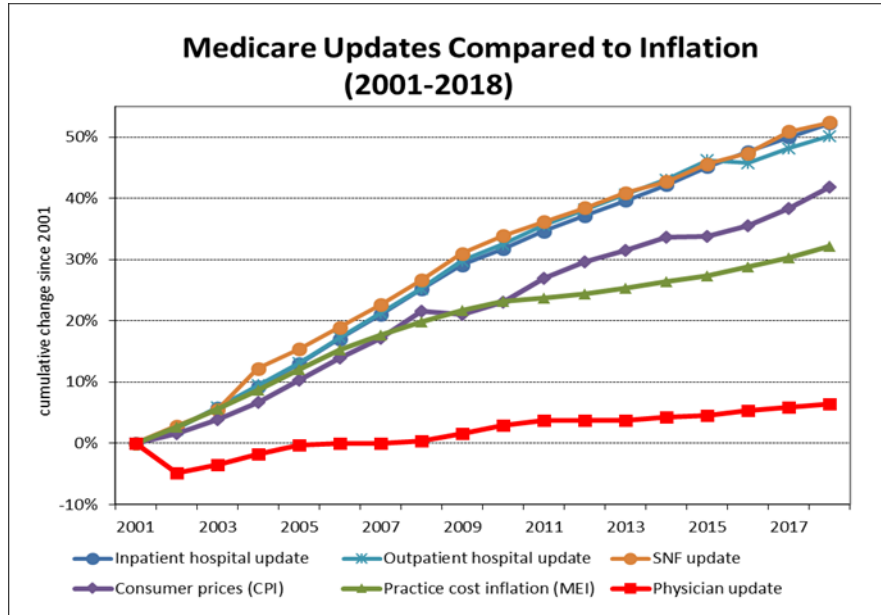
A benchmarked payment based on commercial in-network rates (such as the Energy and Commerce Committee draft calls for) will also have a ripple effect on future contracts, since the out-of-network payment rate becomes the new natural “high” in a geographic area, and future in-network contracts will always be lower. As this continues year-over-year, there will be a downward spiral with unintended consequences for maintaining patient access to emergency care. Sites with high-acuity, complex patients, including emergency departments in rural areas (where it is harder already to recruit physicians) may especially be put at risk with such a benchmark cap on out-of-network payments.

It is important to note that a benchmarked payment based on a percentage of Medicare rates (rather than in-network contracted amounts) is also flawed, because:

- Medicare rates were never intended to reflect market rates and have 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. The 2019 Medicare Trustees Report⁷, specifically states that annual Medicare updates for physicians do NOT keep pace with the average rate of physician cost increases. The Trustees believe

⁷ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf>

that absent a change in the delivery system or future legislative update to physician rates, access to Medicare-participating physicians will become a significant issue in the long term.



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

- Medicare does not accurately reflect 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 never designed for the general population but rather an age-specific group (e.g., does not include pediatrics or obstetrics).
- Medicare is shifting toward a value-based payment approach, and it is unclear how it could be used as a basis for determining a benchmark rate in future years.

In California, for example, where out-of-network payments are based on an average in-network contract rate somewhat similar to the committee's discussion draft, many insurers have decided they don't need contracts because they can simply pay the lower rates established in the new law

and refuse to contract. This has resulted in even further narrowing of networks and reduced access to care.

We are also concerned with the discussion draft's definition of how such in-network rates are set. Experience has shown that when criteria are set in state or federal law for out-of-network emergency service payment, insurers frequently fail to adhere to these criteria, and regulators have failed to enforce such adherence adequately.

For example, as you may know, Congress enacted a provision in the Affordable Care Act forbidding insurers from imposing coverage limitations on out-of-network emergency services that are more restrictive than any limitations imposed on in-network emergency services⁸. In 2010, the Obama Administration issued an interim final rule (IFR) to implement this provision. Since the statute did not ban balance billing, the IFR established a "reasonable payment" for out-of-network emergency services. This payment amount was necessary because, otherwise, insurers might establish extremely low payment rates, thus subjecting patients to very high balance bills. The IFR established for this payment a "greatest of three" (GOT) methodology in which the insurer must pay the greatest of the following:

- The insurer's in-network amount;
- The amount calculated by the same method the plan generally uses for out-of-network services, such as the usual, customary, and reasonable ("UCR") amount; or,
- The Medicare amount.

⁸ Section 2719A(b)(1)(C)(ii)(II) of the Public Health Service Act as added by Section 1001 of the Patient Protection and Affordable Care Act.

Unfortunately, the GOT policy did not have its intended effect of being a reasonable and objective payment standard, and we have repeatedly voiced concern with the second of the GOT standards since the IFR was promulgated in 2010. The UCR amount is subject to insurer manipulation unless it is in some way objectively verifiable, and the term “usual, customary, and reasonable amount” is not an objective standard for calculating out-of-network payments because it is not defined. Accordingly, we have recommended that the data supporting the calculation be subject to independent verification.

In the end, because the underlying statute did not provide an appropriate amount of specificity surrounding payment, we find ourselves in a situation where the regulation that was necessary to fill in the missing details represents a substantial threat to the financial viability of the emergency medicine profession and patient access to qualified emergency physicians and emergency department on-call specialists. Not surprisingly, emergency physicians have seen payments for out-of-network services drop significantly since the GOT regulation was issued in 2010.

For these reasons, we strongly oppose the use of any payment benchmark for setting out-of-network payments in emergency care. Should one be used, it must at least include the following provisions:

- Be directly tied to an independent, transparent, and robust national database such as FAIR Health.
- Data used to determine allowed amount benchmarks should include both in-network and out-of-network claims, from both ERISA and non-ERISA private, commercial plans alike, and include the co-pay and co-insurance. Given the variability that can exist in the payment

amounts from a single insurer to a single provider across its products (i.e., out-of-network ERISA vs. small group vs. individual market), we are concerned the benchmark estimates will be distorted downward.

- Be anchored to a specific year, with a medical cost of living inflation index added each year, to alleviate the “downward spiral” on future contracting described earlier, as well as possible insurer manipulation of the benchmark through contract eliminations.

VIII. Preferred Approach to Resolve Reimbursement Disputes

To prevent significantly distorting negotiations between insurers and providers and wholesale disruption, **we strongly recommend the committee adopt the proven and successful approach used in New York State instead.** The bi-partisan legislative proposal, the “Protecting People from Surprise Medical Bills Act,”⁹ that is soon to be introduced by Reps. Raul Ruiz (D-CA) and Phil Roe (R-TN) specifically use this successful state solution as the federal approach to protecting patients and resolving out-of-network reimbursement disputes.

Under the New York law, which incorporates an independent dispute resolution (IDR) process wherein the provider and insurer participate in arbitration, patients are no longer required to pay out-of-network provider charges for surprise out-of-network services that are higher than the patient's standard in-network co-payment, deductible, or co-insurance amounts. Since enactment, New York successfully reduced the rate of out-of-network patient billing for emergency

⁹ A section by section summary of the “Protecting People from Surprise Medical Bills Act” is available at: <https://ruiz.house.gov/media-center/press-releases/rebs-ruiz-roe-release-outline-bipartisan-legislation-reps-morelle-taylor>.

department services from 20.1% in 2013 to 6.4% in 2015, a near 70 percent reduction.¹⁰ This New York law has since been repeatedly hailed as an example for the rest of the country among the health care community, and provides an effective, balanced solution, while still adhering to free-market principles.

Not all claims are included in the 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 non-profit organization. New York identifies the FAIR Health charge database as an independent entity that can calculate UCR. Effectively, these claims are automatically paid if they conform with this standard. Otherwise, it would potentially cost more to arbitrate these low-dollar claims than the value of the services, and it helps reduce the number of instances when arbitration may be necessary.

Under the established IDR process for emergency services, 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 the 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. The FAIR Health database rates are benchmarks to *guide* final payment, **but they do not**

¹⁰ Cooper, Z.; Morton, F. S.; and Shekita, N. (2017). Surprise! Out-of-Network Billing/or Emergency Care in the United States. National Bureau of Economic Research, <https://www.nber.org/papers/w23623.pdf>

constitute government rate-setting. Both insurers and physicians can submit additional information as outlined in the law to substantiate their payment position.

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 approximately 7 million visits to the emergency department each year in New York¹¹, only 849 emergency claims went to arbitration. As well, the decisions rendered on these were evenly split, further demonstrating that the system is working.

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. 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.¹² Physician networks are stable and not declining. New York insurers reported to Georgetown University

¹¹ <https://nyshc.health.ny.gov/web/nyapd/emergency-department-visits-in-new-york>

¹² Kaiser Family Foundation (2015-2019): “Marketplace Average Benchmark Premiums,” <https://www.kff.org/e4f94bd/>

researchers¹³ that the law had incentivized insurers to have networks of physicians as “expansive as possible.” Further, a FAIR Health report¹⁴ shows that the “billed charge” payment rates have declined by 13 percent since enactment.

It is clear that the New York law has been a success, minimizing disruption, constraining costs, keeping premiums stable, and, most importantly, protecting consumers. **We therefore strongly urge the committee to use this approach rather than the one proposed in the discussion draft.**

IX. Other Recommendations

There are also aspects of the committee’s draft legislation that ACEP believes should be included or modified. First, the draft proposal should be more explicit regarding patient protection from high out-of-network deductibles. The legislation should go further than solely counting cost-sharing payments (defined as copayments and coinsurance) towards any deductible or out-of-network maximum, and instead require deductibles for out-of-network services to apply the same as if those services were provided in-network. Specifically, the legislation should amend Section 2719A(b)(1)(C)(ii)(II) of the Public Health Service Act (42 U.S.C. 300gg-19a(b)(1)(C)(ii)(II)) by inserting “, deductible amount,” after “copayment amount.”

Second, the committee should include a timely payment requirement (applicable to ERISA plans, at minimum) for the automatic payment that requires insurers to have the provider receive payment

¹³ Corlette, S.; Hoppe, O. Georgetown University Health Policy Institute: Center on Health Insurance Reform, “New York’s 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study,” (May 2019). <https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9>.

¹⁴ The New York State Health Foundation, “Issue Brief: New York’s Efforts to Reform Surprise Medical Billing,” (February 2019), <https://nyshealthfoundation.org/wp-content/uploads/2019/02/new-yorks-efforts-to-reform-surprise-medical-billing.pdf>.

within 30 days from receipt of the claim. Failure to provide the proper reimbursement amount or to comply with the prompt pay timeline would trigger a civil monetary penalty (CMP) for the insurer/plan.

Concerning CMPs, we believe that the committee should not penalize providers who may have unknowingly violated the new requirements outlined in the proposal. The CMP applied to providers in the discussion draft who balance bill patients for services in the emergency department or independent freestanding emergency department (IFSED) should only apply if there has been a pattern of behavior and/or willfulness, rather than a single, unknowing instance.

Finally, ACEP appreciates that the discussion draft updates the definitions listed under Section 2719A(b)(2) of the Public Health Service Act to include IFSEDs. ACEP agrees that IFSEDs should be held to the same standards and requirements as both on-campus and off-campus hospital-based emergency departments. We believe that all emergency departments should meet certain criteria – including being available to the public 24 hours a day, seven days a week, 365 days per year; have policy agreements and procedures in place to provide effective and efficient transfer to a higher level of care if needed; and follow the intent of the federal EMTALA statute. This would ensure that all individuals presenting at an IFSED would be provided an appropriate medical screening exam and, if necessary, be provided with stabilizing treatment within the facility's capability or transferred to an appropriate another facility for definitive care. IFSEDs should also have equivalent standards as hospital-based freestanding emergency departments for quality improvement and governance as hospital-based emergency departments.

X. Conclusion

As stated previously, ACEP fervently agrees that more must be done to protect patients and their families from unexpected medical bills and provide greater transparency in these encounters when time permits, and it is appropriate to do so. I would like to thank you again for your work in this regard and, based on my personal experience, I am encouraged that you continue to keep an open mind about the best way to protect these patients and resolve reimbursement disputes between physicians and insurers in a fair, reasonable manner that minimizes federal intrusion into the private marketplace. Fortunately, all parties involved in this debate have expressed their desire to accomplish the goal of taking patients out of the middle. For what remains of the outstanding balance for these services, I encourage you to modify your current draft legislative proposal to use a baseball-style arbitration approach that has proven to be a successful approach to resolving these disputes.

Thank you again for your consideration and for the opportunity to speak to you today on behalf of nearly 40,000 emergency physicians nationwide and the 150 million Americans we treat each year.