

Bipartisan Price Transparency Workgroup Discussion Draft Summary of ACEP Response Letter

General

- ACEP agrees that more should be done to protect patients from their surprise lack of insurance coverage for emergency medical care.
- This draft proposal provides a good starting point for this important and needed discussion.
- However, policymakers must understand the unique nature of emergency care, especially the effect EMTALA and the ACA have had on discouraging health plans from entering into fair and reasonable contracts for in-network services, and cautiously consider the implications of their plan.
- Urge work group to give us time to access vital data needed to more fully analyze these proposals and not prematurely rush to introduce legislation.

Balance Billing

- ACEP has strong concerns about including an across-the-board federal prohibition on balance billing without a corresponding federal minimum benefit standard (MBS).
- Preference is to pair the balance billing ban with MBS defining floor for payments to out-of-network (OON) emergency providers.
- If state/federal jurisdictional issues arise, the balance billing ban should be relocated in the bill so that it would only be invoked when paired with the MBS set by the draft bill for ERISA plans and states with no applicable laws for OON payment methodology.

Minimum Benefit Standard

- The legislation should include language to better clarify that federal law would defer to states on manner and amount of payment only when state law has established clear, specific, and transparent methodology.
- Plans/issuers should provide direct reimbursement to the provider of emergency medical care that includes patient's cost-sharing amounts. The plans/issuers can then recoup patient cost-sharing directly from the patient.
- No practical need for the draft bill's "greatest of two" methodology if sufficient calculation used for provider reimbursement (through usual, customary, and reasonable (UCR) rate, calculated as described below). If necessary to include, the median in-network amount must not include negotiated rates for those providers who participate in Medicare Advantage or Medicaid managed care organizations.

UCR Calculation

- Basing UCR on 125% average allowed amount as proposed in the draft bill can be manipulated by insurers. Over time, they would be able to reduce their maximum allowed amounts, reducing the average for that service.
- We urge the work group to calculate UCR based on 80th percentile of charges as determined by an independent, transparent benchmarking database (like CT, NY, and AK) tied to a specific previous year with medical cost of living inflationary updates annually.
- Alternative approach that has been discussed by some is a blended formula that combines a certain percentile of charges with a percentage (as yet to be determined) of average allowed amounts for a specific geographic region. If this were to be done, it would make sense to tie each portion of that formula to a specific previous year with medical cost of living inflationary annual updates.

- Strongly oppose any approach based on Medicare rates.
- Regardless of method used to determine OON reimbursement, urge work group to consider including the following patient/provider protections:
 - Plans/insurers must provide claims data to independent, non-profit databank;
 - UCR should apply to entire emergency medical encounter for the acute emergency medical condition, not just EMTALA-mandated screening/stabilization;
 - Dispute resolution process paired with a de minimis bill threshold; and
 - Require 30-day prompt pay to provider (including co-pays and co-insurance).

Subsequent Non-Emergency Services

- Oppose the draft bill's creation of a written notification requirement from facility for patient to sign to continue post-stabilization care
- Using EMTALA definitions for "emergency services" and "emergency medical condition" creates practical problems for emergency department operations.
- The point in time at which a patient is stabilized is not a clinically identified endpoint, does not create a bright line to serve as a reimbursement cut-off point, and may be determined at a later point in time than when stabilization was achieved. For these reasons, it would be impractical for deciding when a patient must receive notification and when a MBS will no longer apply.
- Insurer notification requirement would be more useful and relevant than patient notification.

HHS Study

- Recommend broadening the scope and authority of the HHS study (on impact of the bill) by establishing an Access to Quality and Affordable Emergency Care Commission that evaluates:
 - Adequacy of patient protections to ensure access to emergency care under Prudent Layperson Standard,
 - How statutory requirement for patient access to emergency care is effectuated,
 - Degree to which uncompensated care is borne by clinicians under EMTALA, and
 - Value of DSH-type supplemental funding for such uncompensated care.

Additional Patient Protections

- Establish a federal patient emergency care access standard
- Increase transparency for policyholders for their emergency medical coverage by
 - Specifying insurance product on patient's member ID card so clear to both patient and treating providers, and;
 - Providing enrollees with meaningful and simple explanations of emergency care coverage guaranteed under federal law.