



May 28, 2019

The Honorable Frank Pallone  
2125 Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Greg Walden  
2322 Rayburn House Office Building  
Washington, D.C. 20515

**Re: Request for Comment on E&C Surprise Billing Discussion Draft**

Dear Representatives Pallone and Walden:

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 resolving the issue of surprise medical bills in a constructive and substantive manner, and we appreciate the opportunity to provide comment on your discussion draft of legislation intended to address this important issue.

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 work continues on this legislation, 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 reasonable 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 care there. 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 Public Health Service Act), which then shifts the majority (if not the entirety) of the cost of the encounter to the patient, rather than the insurer.

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Therefore, 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 in actuality have provided them with little to no protection against the cost of care, due to high deductibles and other opaque or complicated health plan designs.

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. However, we need a policy remedy that more directly addresses the root cause of surprise bills – inadequate insurance networks. A legislative solution should demand increased transparency from insurance companies and make sure that patients can better understand the limitations of their insurance.

While current law requires the patient to pay the same coinsurance and copayment amount regardless of whether emergency care is provided in-network or out-of-network, ACEP strongly believes that this protection should extend to the patient’s deductible – bringing down the amount a patient must pay out of their own pocket before their insurance kicks in. This key change would encourage health plans to expand their networks for emergency care.

In addition, ACEP calls for ‘baseball-style’ arbitration to ensure a fast and fair resolution of any billing issues between insurers and providers. This simple, efficient, and proven process has effectively incentivized providers to charge reasonable rates and insurers to pay appropriate amounts in several states. In New York, this arbitration model has curbed the number of surprise bills without raising costs.

With these principles in mind, please find below our detailed comments regarding this draft legislation and the specific requests for information. We stand ready to work with you and the members of the Committee to develop a more impactful and meaningful bill that protects our patients and their access to high quality emergency care.

Should you have any questions, please do not hesitate to contact Laura Wooster, MPH, ACEP’s Associate Executive Director for Public Affairs, at [lwooster@acep.org](mailto:lwooster@acep.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Vidor E. Friedman". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Vidor E. Friedman, MD, FACEP  
ACEP President

## **Specific Legislative Comments**

Before diving into the specific topic areas identified by the Committee for stakeholder feedback, ACEP would first like to identify some areas in the discussion draft that are beyond the scope of the targeted questions.

First, ACEP believes that the discussion draft does not sufficiently protect patients from the high out-of-network (OON) deductibles they are currently facing. The legislation should go further than simply counting cost-sharing payments (defined as copayments and coinsurance) towards any deductible or out-of-network maximum, and instead require deductibles for OON 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 “prompt pay” requirement (applicable to ERISA plans, at minimum) for the automatic payment that requires insurers to have the provider receive payment 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.

With respect to CMPs, we believe that the Committee should not penalize providers who may have unknowingly violated the new requirements. The CMP applied to providers in the discussion draft who balance bill patients who receive 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 other 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.

**Increasing Transparency for Consumers. Our health care system is confusing for even the most educated consumers. The Committee is interested in feedback on ways to help consumers better understand their health plans and which providers are in their network.**

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. Emergency providers 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 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. This is why

the [ACEP Framework](#) calls for insurers to be required to include the policyholder's in- and out-of-network deductibles for emergency 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 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 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 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, or result in serious impairment of or dysfunction to 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 charges, 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 – such as FAIR Health. Such a database should be transparent, statistically valid, and protected against conflict of interest.

**Ensuring Network Adequacy. Consumers deserve adequate networks that offer the right care at the right time. The Committee seeks feedback on ensuring that networks are sufficiently meeting the needs of individuals.**

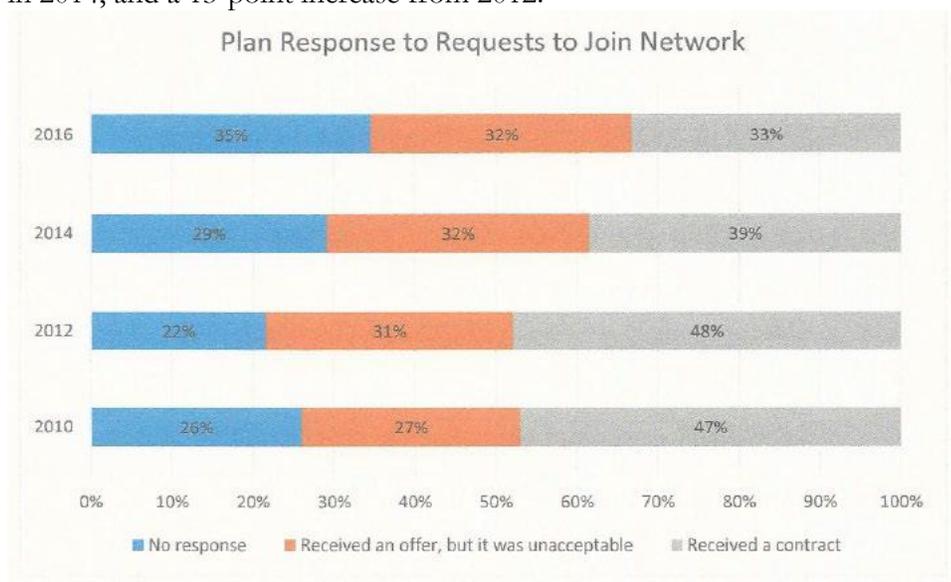
In many parts of the country, insurers have near-monopolies (if not full monopolies) of market share; there are in fact numerous examples of a single plan controlling more than half of the market. Such market power allows insurers to offer take-it-or-leave-it contracts and narrow their physician networks, 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.<sup>1</sup>

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<sup>1</sup> Kaiser Family Foundation, "Market Share and Enrollment of Largest Three Insurers- Large Group Market," available at: <https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market>.

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 certainty of reimbursement directly from the insurer, rather than needing to pursue it from patients following their care. While all 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 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.<sup>2</sup>



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 insurance plan but found it unacceptable (i.e. turned it down) remained stable. From this, we can draw the conclusion 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 out-of-network rate of 125% of Medicare). Some insurers are terminating contracts unless physicians accept payment reductions as large as *forty percent*. Other payors are reportedly closing their networks to new physicians and most are reducing their physician networks overall in an effort 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.

Congress should seek to at minimum 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

<sup>2</sup> 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](https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/2016_Physician_Survey_Findings.pdf)

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 effort 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, the Committee should include specific language in the legislation to ensure insurers maintain adequate provider networks. Otherwise, insurers will simply put profits over patients. 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.

**Encouraging the Development of State All-Payer Claims Databases. All-payer claims databases have the potential to bring greater transparency to health care costs and spur innovative policy solutions. The Committee requests feedback on how to aide states in developing robust all-payer claims databases.**

ACEP supports the development of robust all-payer claims databases (APCDs) that mandate the collection of claims from all payers. Fifteen states have APCDs in place and numerous others are either considering or in the process of implementing APCDs. States can mandate 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 voluntary 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 B of a report](#) prepared by the University of Chicago's NORC for a summary of APCD features by 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 & Commerce Committee considers creating a grant program to fund state efforts to implement new or maintain existing APCDs, the Committee must specify certain criteria for APCDs that states must agree to adhere to in order 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 does not include any such requirements or even provide guidance for states to consider when implementing new APCDs or maintaining existing APCDs. Furthermore, the draft does not specify the purposes for which states can use the APCDs developed using the grant funding, which would definitely 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 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 must contribute data to it.**

An additional technical issue with the current discussion draft relates to the appropriations language. The Committee should clarify that the \$50 million appropriation 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.

**Establishing a market-based benchmark to resolve out-of-network payment disputes between providers and insurers. Payment disputes between providers and insurers must be resolved in a manner that takes the patient out of the middle, is transparent and does not increase federal healthcare expenditures. The Committee requests feedback on how to adequately provide payment in these situations through a transparent, non-inflationary mechanism.**

ACEP agrees 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.

Yet we have strong concerns and oppose use of a benchmark for establishing out-of-network (OON) payment amounts. We noted previously in our response 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 faster payments.

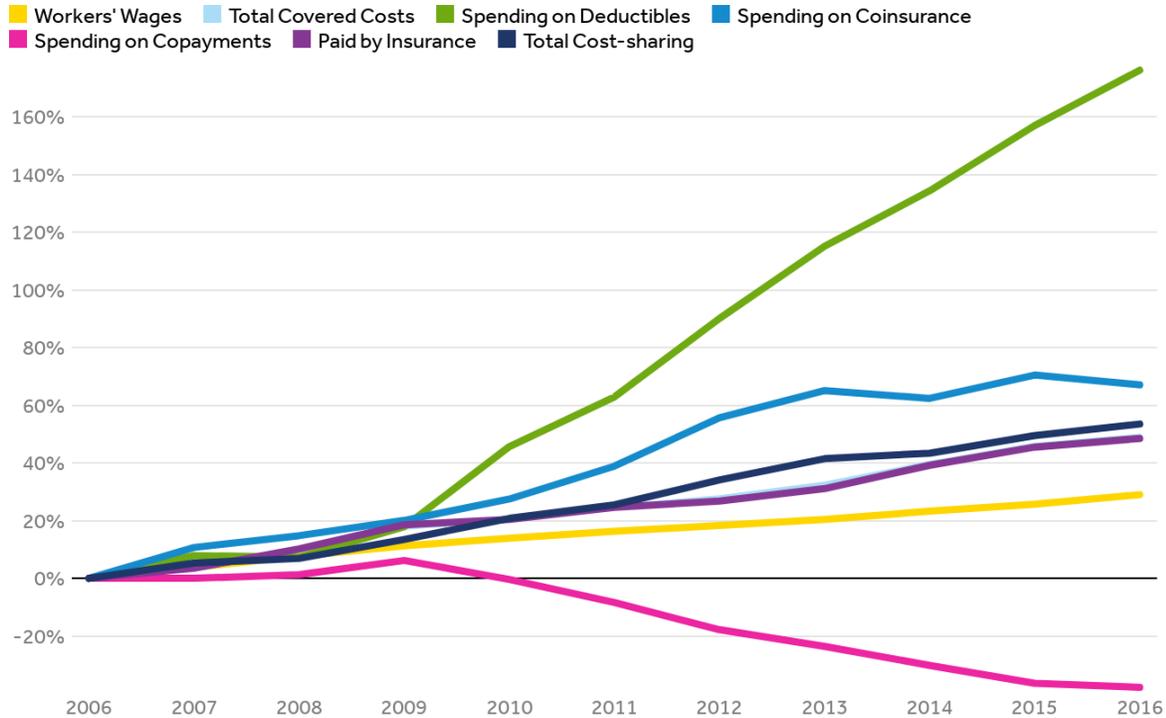
Allowing insurers to access a discounted contract rate (via benchmarked OON payments) without providing the benefits of contracting in exchange will in turn discourage contracting altogether and result in even narrower networks of physicians and less patient choice. Discounted OON payments will severely 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 uncompensated and under-compensated 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 Foundation (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 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 graph below) has resulted in a corresponding increase in the amount of bad debt that emergency physicians incur.

### Cumulative increases in health costs, amounts paid by large employer insurance coverage, amounts paid for cost sharing and workers wages, 2006-2016



Source: Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2006-2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 2006-2016. • [Get the data](#) • [PNG](#)

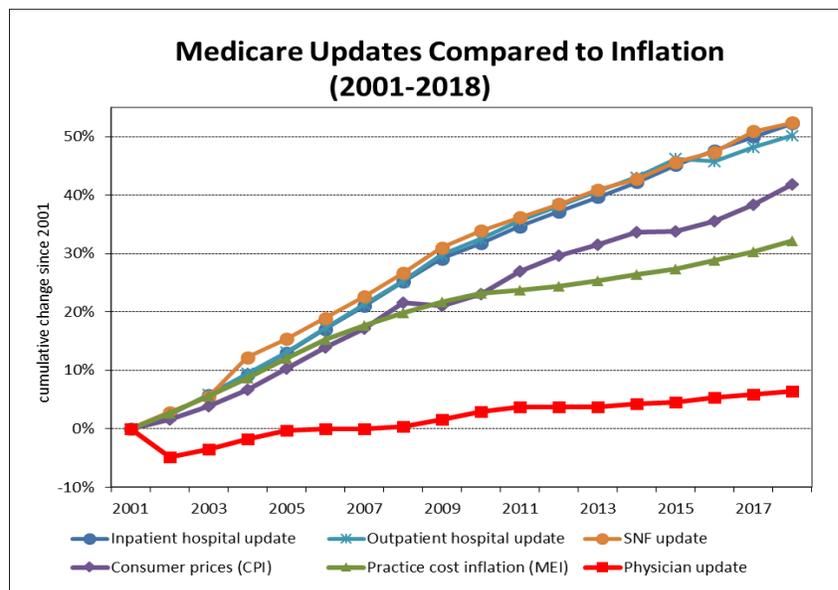
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Accompanied by the further decline in Medicare reimbursements since then, as well as Medicaid expansion in many states that greatly increased the proportion of Medicaid patients, such losses continue to grow. Emergency physicians are the only safety 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 legislation 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 disastrous consequences for maintaining patient access to emergency care. High acuity and complexity sites, including EDs in rural areas (where it is harder already to recruit physicians) may especially be put at-risk with such a benchmarks 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 Report<sup>3</sup>, specifically states that annual Medicare updates for physicians do NOT keep pace with the average rate of physician cost increases. The Trustees believe 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.
- Medicare does not accurately reflect practice costs. In fact, 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 even be used as a basis for determining a benchmark rate in future years.



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

In California, for example, where OON 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 for *how* such in-network rates are set. Past 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 adequately enforce such adherence.

<sup>3</sup> The 2019 Medicare Trustees Report is available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf>

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 services<sup>4</sup>. 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.

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 to patient access to qualified emergency physicians and ED 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.

We strongly oppose use of any payment benchmark for setting OON payments in emergency care, but should one be used, it must therefore at minimum:

- 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 copay and coinsurance. Given the variability that can exist in the payment amounts from a single insurer to a single provider across its own products (i.e. out-of-network ERISA vs. small group vs. individual market), we are concerned the benchmark estimates will be skewed 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 in this section as well as insurer gaming of the benchmark through dropping some contracts.

#### Use a Proven and Successful Approach to Resolve Billing Disputes

To prevent significantly distorting negotiations between insurers and providers and wholesale disruption, **we instead strongly recommend the Committee adopt the proven and successful approach used in New York State**. The bi-partisan legislative proposal, the “Protecting People from Surprise Medical Bills Act”<sup>5</sup>,

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<sup>4</sup> 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.

<sup>5</sup> 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/rep-ruiz-roe-release-outline-bipartisan-legislation-reps-morelle-taylor>.

introduced by Reps. Raul Ruiz (D-CA) and Phil Roe (R-TN) specifically uses this successful state solution as the federal approach to protecting patients and resolving out-of-network billing 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 copayment, deductible, or coinsurance rate. Since enactment, New York successfully reduced the rate of out-of-network patient billing for emergency department services from 20.1% in 2013 to 6.4% in 2015, a near 70 percent reduction.<sup>6</sup> This New York law has since been repeatedly hailed as an exemplar for the rest of the country among the healthcare 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 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. The FAIR Health database rates are benchmarks to guide final payment, but they do not 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 millions of visits to the emergency department in 2018, only 849 emergency claims went to arbitration. 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.<sup>7</sup> Physician networks are stable and not

<sup>6</sup> 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>.

<sup>7</sup> Kaiser Family Foundation (2015-2019): “Marketplace Average Benchmark Premiums,” <https://www.kff.org/e4f94bd/>.

declining. New York insurers reported to Georgetown University researchers<sup>8</sup> that the law has incentivized insurers to have networks of physicians as “expansive as possible.” Further, a FAIR Health report<sup>9</sup> shows that the “billed charge” payment rates have actually 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 that proposed in the discussion draft.**

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<sup>8</sup> 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>.

<sup>9</sup> 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>.