American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

February 11, 2020

The Honorable Richard Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Neal and Ranking Member Brady:

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, thank you for your continued dedication and thoughtful efforts to address the issue of out-of-network billing or "surprise" medical bills by introducing the "Consumer Protections Against Surprise Medical Bills Act of 2020." ACEP supports this legislation and is encouraged that your committee recognizes that a mediation process with no qualifying threshold must be part of a reasonable congressional solution to the issue of surprise bills. Like you, ACEP remains committed to finding a fair and equitable solution that takes patients out of the middle of payment disputes that may arise between physicians and insurers.

Emergency physicians are committed to ensuring the patients to whom we provide life-saving treatment each day are protected from surprise bills. Your measured approach sets a promising foundation for additional discussion, and while we remain concerned about some provisions in the legislation (noted below), ACEP looks forward to working with your committee on improvements to the bill.

First, we are appreciative of several important changes that were made to the legislation since the initial release of the text, including clarification of the definition of cost-sharing to include copayment, coinsurance, *and* deductible. This will address a critical gap in existing law to ensure that patients who may receive care from an out-of-network physician are only held responsible for their in-network cost sharing amounts. Additionally, the revised language regarding assignment of benefits will help ensure that patients are fully taken out of the middle of the payment process. Finally, the bill includes a number of important patient protections that ACEP has long been advocating for, such as requiring the deductible to be listed on policyholders' insurance cards, and for these we applaud you.

There remain some provisions and issues we believe can still be improved, and we sincerely appreciate your continued consideration as you move forward. These include:

1) **Prevent a rate-setting impact from median contracted rates.** We are deeply concerned by the potential for a rate setting impact that could result from the inclusion of the median contracted rate as a criterion for consideration in mediation, particularly with their potential long-term impacts on future rates and incentives to contract. A payment based only on median contracted rates will 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. In fact, the Congressional Budget Office acknowledges as much in its most recent estimate on your committee's legislation, noting

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that (emphasis added) "…payment rates for both **in**- and out-of-**network care** would move toward the median in-network rate which tends to be lower than average rates." High acuity and complexity sites, including emergency departments (EDs) in rural areas (where it is harder already to recruit physicians) may especially be put at-risk should these rates become the de facto standard. The legislation must ensure that full consideration be given to other factors or materials submitted by the parties at their choosing in the mediation process, such as the market share held by the out-of-network physician or health plan, the physician's level of training, education, experience, outcomes, or quality metrics, the complexity of the services rendered, other contracted rates, etc.

Furthermore, the use of contracted rates allows the insurer to continue using "black box" methods to determine physician payment without providing any means to verify the data. While the legislation includes audit processes, we are concerned these may not sufficiently ensure transparency and accuracy. Insurer datasets have historically proven unreliable, as evidenced by the 2009 class action settlement against United Health Care for $300 million in which the usual, customary, and reasonable database for determining out-of-network payments operated by its subsidiary, Ingenix, was found to be inaccurate and unreliable. More recent efforts by the Georgia Department of Insurance to collect plan-reported data on mean and median contracted payment rates yielded similar inconsistencies and was abandoned. We urge instead using a known independent, transparent, and verifiable database for the purposes of this provision, which will also be more reflective of the actual market in that provider's geographic area by tying the median contracted amount to the rate for *all* commercial insurers in that area rather than just for one.

2) **Use 2018 as the base year for calculating contracted rates.** ACEP recognizes that the legislation specifies the maximum of the median contracted rate, and hopefully this figure is less susceptible to manipulation of rates that already started occurring as early as Summer of last year as Congress considered surprise billing legislation. However, we believe that using 2018 would provide a more accurate and straightforward picture of in-network rates that would obviate potential gaming of the system that may have occurred in anticipation of congressional action on this issue. As noted by Representative Larry Bucshon during the House Committee on Energy and Commerce markup of H.R. 3630, some insurers began to terminate contracts and offered to renew at significantly lower rates with the expectation that Congress would establish a federal benchmark payment rate based on median in-network amounts for the 2019 plan year, which had not ended yet.

3) **Ensure that federal plans are not included in calculation of contracted rates.** We request that the legislation clarify that contracted rates should be calculated using only commercial rates and do not include Medicare Advantage and Medicaid Managed Care plan rates. As currently written, the bill's language would not provide an "apples to apples" comparison to the out-of-network claim that is in dispute and artificially depress any median calculations. The legislation already includes such language in its instruction to the Secretary for developing a substitute rate for health plans lacking sufficient data to do so on their own, when it calls for determining it "based on a similarly situated health plan that is not a Federal health care program." We request that this qualification be extended to the insurer's own calculations**.**

4) **Clarify that "response" means "payment" and require plans to issue in a timely manner.** This language substitution (p. 125, line 1) would clarify that insurers are still required to issue a payment to a provider. We remain concerned that the term "response" could be interpreted as just an offer or some other communication, and this could become a means by which payment is delayed. We understand that the rule of construction (p. 179) is aimed at addressing this issue, but we believe that replacing "response" with "payment" would provide additional clarity and certainty for physicians. We urge the committee to include a requirement for insurers to provide a physician with payment that is reasonable and in line with the services provided by the out-of-network physician within 30 days from receipt of the claim. To encourage compliance, failure to provide the proper reimbursement amount or to comply with the timeline would trigger a civil monetary penalty (CMP) for the insurer/plan.

5) **Consider a less-prescriptive open negotiation period.** The inclusion in the bill of an open negotiation period to encourage physicians and health plans to resolve payment disputes without needing to go to mediation is sensible. However, we have potential concerns with the provision requiring plans and providers to disclose to each other information about median contract rates and reimbursement, and we seek additional clarity. It is unclear what impact this kind of untested approach could have on future contract negotiations for both the insurer and the provider involved. It is unclear what kind of impact this kind of untested approach could have on future contract negotiations for both the insurer and the provider involved. As well, it is unclear if physicians in many cases will even have the latitude to provide the requested information to the out-of-network health plan, as they are often bound by so-called gag clauses in their existing contracts with insurers from disclosing these rates to other parties.

6) **Ensure open negotiation and mediation timelines align with business workflows (p. 127, line 8; p. 129, line 19; p. 130, line 12; p. 134, line 19).** Given the limitations that many businesses would face in providing information within 2-, 3-, or 5-day deadlines, especially when spanning a weekend, we request that the language describing any deadlines in the legislation shorter than 7 days be modified to specify these are business days.

Once again, ACEP appreciates the thoughtful, measured, and bipartisan approach you and your staff have taken to resolve the issue of surprise medical bills. Your legislation puts patients first and provides critical consumer protections, and also seeks to strike an appropriate balance in negotiations without tipping the scales too far in favor of one entity or another. 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.

Sincerely,



William P. Jaquis, MD, MSHQS, FACEP
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