October 10, 2018

VIA EMAIL

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Re: Discussion Draft on Surprise Billing

Dear Senators Cassidy, Grassley, Young, Bennett, Carper, and McCaskill:

Thank you for inviting the Emergency Department Practice Management Association (EDPMA) to comment on the discussion draft addressing surprise billing. EDPMA is one of the nation’s largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA’s membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation’s emergency departments. **Together, EDPMA’s members deliver (or directly support) health care for about half of the 141 million patients that visit U.S. emergency departments each year.** We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

Because we handle over half of the emergency visits in the nation, we are focusing our comments on the provisions that impact emergency care. We suggest a number of improvements
which would significantly reduce the financial burden on patients, improve patient access to emergency care, and increase transparency including:

1. Set the Minimum Benefit Standard (MBS) at the 80th Percentile of Charges Based on an Independent and Unbiased Charge Database,
2. Limit the Balance Billing Ban to Instances when the Insurer Reimbursed the Provider, at Minimum, at the 80th Percentile of Charges Based on an Unbiased Charge Database,
3. Minimize Future Manipulation by Tying the MBS to Data from a Prior Year,
4. Encourage and Enforce Broader Network Adequacy Standards,
5. Like New York State, Require Insurers to Pay Physician Charges for Claims Under a Monetary Threshold which are Below 120% of the 80th Percentile of Charges,
6. Require Insurers to Pay Allowed Amounts Directly to the Emergency Provider,
7. Apply the Federal MBS Unless the State Standard is Sufficiently Unambiguous and Enforceable and Improves Patient Access to Emergency Care,
8. Require Insurers to Disclose Out-of-Network and In-Network Methodologies and Data to Both Patients and Providers,
9. Require Insurers to Disclose the Type and Location of the Plan on the Members’ Insurance Card,
10. Require Insurers to Appropriately Disclose and Comply with the Federal Prudent Layperson Standard, and

A. THE PROBLEM

1. Emergency Care Provides Unique Benefits and Poses Unique Challenges

It is important to address the many unique aspects of emergency care. Emergency departments are the nation’s healthcare safety net, providing care to all who need it, 24 hours a day, 7 days a week. Federal law -- the Emergency Medical Treatment & Labor Act (EMTALA) -- ensures that everyone visiting the Emergency Department will receive care, no matter the ability to pay. So, it is not surprising that emergency physicians provide significantly more than their fair share of uncompensated and undercompensated care. Although emergency physicians are only 4% of physicians, they provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients. In many states, Medicaid and CHIP reimbursement is significantly below Medicare rates and may not even cover the cost of care. So, it is particularly important for legislators to make sure that for-profit commercial insurers contribute their fair share for covered and federally mandated care. Otherwise, fewer physicians will be attracted to the emergency medicine specialty, lines at the emergency department will grow, and some emergency departments, especially those in rural areas, will be in danger of closing down.

Typical market forces at play in the healthcare economy are distorted by the nature of emergency medicine. For instance, EMTALA creates a disincentive to negotiating fair contracted rates in emergency medicine. Because emergency providers cannot turn patients away, there is little interest in establishing network adequacy requirements for emergency physicians. Further, emergency medicine providers meet their patient care obligations first, and then seek reimbursement from payers. As a result, insurance companies can significantly reduce their
financial responsibility for emergency care by having few, if any, emergency providers in their networks and shifting the cost of emergency care onto patients in the guise of higher out-of-network deductibles, with greater “first dollar” exposure shifted to patients. Because emergency providers have little negotiating power under these circumstances, in-network rates typically are not a reliable benchmark for a fair market rate. Unfortunately, both the ACA and state laws requiring network adequacy have not been stringent enough or enforced in such a way as to require that health plans provide sufficient numbers of in-network hospital-based physicians.

There are also many barriers to collecting the emergency patient’s cost-sharing amount. Most outpatient providers are able to collect the copay before providing care and can refuse care when a patient has a history of not paying the bills. However, EMTALA prevents emergency physicians from doing so. Therefore, emergency physicians often cannot collect copays. Moreover, patients are often surprised by the large gap in their insurance for “covered” emergency care and dispute their emergency bills.

In recognition of this situation, the U.S. Department of Health & Human Services, along with the Treasury and Labor Departments, noted while establishing the greatest-of-three rule that “it would defeat the purpose of the protections in the statute if a plan or issuer paid an unreasonably low amount to [an emergency] provider, even while limiting the coinsurance or copayment associated with that amount to in-network amounts.” Thus, “a plan or issuer must pay a reasonable amount for emergency services by some objective standard.” They issued the greatest-of-three rule which provides that – at minimum – insurers must pay the greatest of:

1. The amount negotiated with in-network providers for the emergency service,
2. The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount) and
3. The Medicare rate.

At the time this minimum benefit standard was established, the standard was tied to both “allowed amounts” and “charges” because most insurers were reimbursing out-of-network emergency providers at usual, customary and reasonable charges: the 80th percentile of charges. Unfortunately, because the standard was not drafted well, insurers were able to manipulate the standard and develop less generous reimbursement formulas over the last few years.

2. The Current Minimum Benefit Standard (MBS) for Emergency Care is Easily Manipulated by Commercial Insurers and Enables Them to Shift Most of the Cost of Care to Patients

Although, the greatest-of-three standard was well intentioned, it is vague, unenforceable, and easily manipulated by insurance companies. This is because it failed to tie the standard to usual and customary charges and to an independent and unbiased charge database. Instead, it relies on in-network rates or the insurer’s formula for calculating out-of-network rates both of which are not publicly available and are easily manipulated by insurers. Furthermore, this lack of transparency makes it difficult for patients and providers to identify noncompliance. Motivated patients can take advantage of cumbersome regulations that provide access to some of this information; however, providers – who are mandated to provide the care – cannot.
So, it is no surprise that we have seen an increasing number of complaints from patients who face an increasingly large surprise gap in their insurance for covered emergency care since the greatest-of-three standard was enacted. Patients find that private insurance “coverage” of emergency care is often a misnomer. Insurers are often unwilling to negotiate fair and sustainable contracted rates, so more patients are responsible for a greater percentage of the emergency bill in the form of deductibles and “balance bills.” Moreover, inadequately low out-of-network reimbursement also leads to inadequate in-network reimbursement.

So, instead of shoring up emergency reimbursement rates, reimbursement decreased after the greatest-of-three rule was adopted. A few years ago, the American College of Emergency Physicians (ACEP) studied the issue and concluded that:

“ACEP analyzed the claims database of one of the largest national emergency physician billing companies. The claims in this database represent approximately seven percent of emergency physician claims submitted nationally. The analysis focused on claims submitted to two national health plans in 2013. Consisting of over 200,000 claims from across the country, these claims are believed to be representative of the health insurance industry in general.

The analysis shows that both plans had substantially lowered the benefits to their enrollees for OON emergency physician services during 2013. Payments from one plan decreased by an average of $61. Payments from another plan decreased by an average of $325. ACEP then extrapolated the underpaid claims from these plans across all commercial OON emergency physician claims covered. It would appear that these two plans alone represent an annualized transfer of more than $575 million dollars in liability for OON emergency physician claims.” (Attachment 1).

At the same time, insurance companies enjoyed substantial profits.

So, we were encouraged when Congressional report language tied to the 2017, 2018, and 2019 appropriations bills directed the Administration to clarify the meaning of “usual, customary and reasonable amount” in the greatest-of-three rule and urged the Administration to tie that definition to an independent charge database. Unfortunately, the Administration has not fulfilled this Congressional direction. We welcome a legislative fix if the new standard improves patient access to emergency care and protects the all-important healthcare safety net.

3. **The Discussion Draft Could Exacerbate the Problems with the Current MBS**

Although the discussion draft is well-intentioned, it does not solve many of the most egregious problems posed by the current standard described above. Most importantly, it does not fix the fundamental problem that insurers can unilaterally manipulate the minimum benefit standard and can do so in secret. So, emergency providers are still in an untenable “catch 22” situation where they can neither turn patients away nor demand fair payment for federally mandated care. This poses a significant threat to the healthcare safety net.

Although the discussion draft would ban balance billing, **it does not address the more significant concern that insurers are shifting most of the cost of emergency care to patients in the guise of their out-of-network deductible.** The draft does not encourage insurers to contract with emergency physicians through full and fair negotiations. If the legislation does not encourage insurers to offer more robust networks of emergency physicians, insurers will be able to continue to shift the cost of care to patients.
When market forces work properly, out-of-network reimbursement is significantly higher than in-network rates. Otherwise, insurers would be discouraged from negotiating fair and sustainable in-network rates. Yet, the discussion draft only requires insurers to pay an out-of-network rate that is equal to in-network rates. This threatens to undermine half of the contracts because health plans would be incentivized to cancel contracts above the mean.

For instance, in Oregon, after legislation banning balance billing was passed without an adequate minimum benefit standard, some insurers tried to negotiate rates that were about 25% lower than their existing contract rates and cited the balance billing ban as the reason they felt they could get the reduction. When the MBS is nonexistent or inadequate and balance bills are banned, health plans can successfully make unreasonable demands to reduce contracted rates.

A better approach was implemented in Maryland where, in 2010, the state established a number of payment floors for out-of-network care. One of those payment floors is 140% of the average in-network rate for similarly licensed professionals.

We are concerned that the new standard could ultimately lead to lower revenue for emergency physicians. The ban on balance billing, viewed on its own, would reduce provider revenue. However, at first glance, the proposed MBS could offset a portion of this loss by increasing the MBS from 100% of allowed amounts (based on the greatest-of-three rule) to 125% of allowed amounts. Unfortunately, because the insurer can manipulate "allowed amounts," using closely guarded, confidential and proprietary information, and changing their formula for calculating reimbursement, it can unilaterally reduce its reimbursement formula and simply nullify this proposed increase!

Moreover, the proposed MBS depends on a database of "allowed amounts." Unfortunately, "allowed amounts" databases are not as robust as "charge" databases as insurers generally do not like to share proprietary information with their industry competitors. So, in some geographic areas, the most prevalent payer has not contributed any "allowed amounts" to a public database.

**B. SUGGESTED IMPROVEMENTS TO THE DISCUSSION DRAFT**

1. **Set the Minimum Benefit Standard at the 80th Percentile of Charges Based on an Independent and Unbiased Charge Database**

   We urge you to tie the Minimum Benefit Standard (MBS) to market forces by establishing a minimum benefit standard (MBS) at the 80th percentile of charges based on an independent transparent unbiased charge database. Historically, out-of-network reimbursement was set at usual and customary charges. These reimbursement rates created an incentive for insurers to negotiate a fair and sustainable in-network rate below those market rates. This interest in contracted rates, in turn, significantly reduced the financial burden placed on patients because fewer patients had to pay their deductible when visiting the emergency department.

   Some commercial insurers continue to reimburse at the 80th percentile of charges. (reference to United Healthcare https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits.) Commercial insurers would not voluntarily use this standard if it were excessive.
Similarly, four states have established a minimum benefit standard based on physician charges: Connecticut, New York, Alaska, and Florida. Three of those states (CT, NY and AK) require insurers to contribute, at minimum, 80th percentile of charges based on an unbiased transparent charge database. Florida requires a minimum payment at “usual, customary, and reasonable provider charges in the community,” but unfortunately failed to define that term. A minimum benefit standard set at the 80th percentile of physician charges is also under consideration in Georgia (SB 359), Kentucky (SB 79), Rhode Island (HB 7008), Tennessee (HB 2353 and SB 2640), and Oklahoma (SB 1478). Attachment 2 illustrates that after this charge-based standard was adopted in two states, physician charges (based on FAIRHealth data) stabilized and the annual increase in charges was consistent with inflation rates. In other words, a charge-based standard did not lead to excessive charges.

Moreover, in November 2017, after working with stakeholders on all sides of the issue, the National Council of Insurance Legislators (NCOIL) adopted model legislation addressing out-of-network reimbursement. The NCOIL model legislation defines “usual, customary, and reasonable” as 80th percentile of an unbiased charge database.

If the FAIRHealth charge database is used as the benchmarking this would also improve transparency because the data is available to all stakeholders – insurers, providers, patients, and regulators.

If, however, this bipartisan workgroup ultimately decides to tie the MBS in some way to allowed amounts and in-network rates, we urge you to replace the standard based on “allowed amounts” with a blended rate which takes into account both “125% of allowed amounts” and “charges.” Thus, any further manipulation by insurers of the reimbursement formula is counterbalanced by a calculation of usual and customary charges. This would also ensure that the standard has some tie to market rates.

When considering possible alternatives to the proposed standard, we urge you not to tie the MBS to a percentage of Medicare. Medicare rates were never intended to reflect market rates and they were eroded, relative to commercial rates, by the flawed Sustainable Growth Rate formula. Medicare rates are based on the amount of money that is available in the federal budget. There is no reason to base a reimbursement rate paid from for-profit commercial insurers to privately-employed physicians on government rates. Also, tying reimbursement to a percentage of Medicare would be a windfall for insurers who are already reaping high profits. Such a standard would further exacerbate the problem that emergency physician are serving mostly patients who are covered by government plans that also reimburse at below-market rates. Further, Medicare rates have not kept up with inflation and are not expected to do so in the future (see Attachment 3). The state of California considered a minimum benefit standard based on a percentage of Medicare. California legislators were concerned about preserving the healthcare safety and chose to specifically exempt emergency care from that inadequate standard.

2. **Limit the Balance Billing Ban to Instances when the Insurer Reimbursed the Provider, at Minimum, at the 80th Percentile of Charges Based on an Unbiased Charge Database.**
If the workgroup chooses not to require insurers to pay at the 80th percentile of charges, we urge you to limit the ban on balance billing to instances when the insurer reimbursed at this rate. This would allow insurers to protect their insureds from balance bills by simply reimbursing at usual, customary, and reasonable charges. Yet, it would not tie the hands of emergency providers who are paid below market rates for federally mandated care. This provision would protect the healthcare safety net and improve patient access to emergency care.

3. **Minimize Future Manipulation by Tying the MBS to Data from a Prior Year**

Whether you adopt a minimum benefit standard tied to “allowed amounts,” “charges,” or both, we urge you to prevent future manipulation by tying both measures to a specific calendar year in the past and adjust for medical inflation. Therefore, neither insurance companies nor providers could easily and unilaterally manipulate those measures. This approach was utilized in Maryland, through a state law that was enacted in 2010, which set a number of payment floors, including one based on final allowed amounts in 2009, adjusted for inflation.

As discussed earlier, insurance companies have been unilaterally changing their reimbursement formulas. On the other hand, FAIRHealth data in New York and Connecticut illustrates that emergency providers have not been increasing charges beyond what would be expected to reflect inflation. Nevertheless, we urge you to prevent manipulation by either insurers or providers going forward by tying these standards to data from a specific prior year.

We also recommend that you tie any standard to “the 80th percentile of” a data set and not the “average” because averaging gives too much weight to outlier claims.

4. **Encourage Broader Network Adequacy Standards**

The MBS should incentivize insurers and providers to negotiate sustainable in-network rates because this benefits insurers, providers, and patients. Unfortunately, many states do not have network adequacy standards for emergency physicians. Even where there are standards, states often do not enforce them. This means patients pay for more of their care in the form of their deductible. And this problem is exacerbated by high deductible plans which are often purchased by low-income patients who cannot afford to pay that deductible. (See, e.g., *Financial Burden of Employer-Sponsored High-Deductible Health Plans for Low-Income Adults With Chronic Health Conditions*, by Abdus S, Keenan PS., *JAMA Intern Med.*, Published online October 8, 2018 (47 percent of low-income adults with multiple chronic conditions and high-deductible plans were paying more than 20% of their family income on out-of-pocket healthcare expenses.) Again, insurance companies profit and emergency provider revenue decreases.

5. **Like New York State, Require Insurers to Pay Physician Charges for Claims Under a Monetary Threshold which are Below 120% of the 80th Percentile of Charges**

We urge you to require insurers to pay physician charges when charges are below a monetary threshold and are below 120% of the 80th percentile of charges based on an unbiased charge database.

News accounts of surprise emergency bills often report on situations where patients owe a great deal of money for helicopter or ambulance transportation, complicated care involving many
different providers, or a high deductible plan. However, in most cases, emergency physician claims are less than $1,000 and the patient is liable for only a small portion of that bill.

So, some states have passed laws that require insurers to pay physician charges for claims under a particular monetary threshold. For instance, New York law requires insurance companies to pay provider charges if the claim for emergency care is below $600 (adjusted for inflation) and is below 120% of the 80th percentile of charges. This provision not only encourages providers to charge below both thresholds, it also allows everyone (patients, providers, and insurers) to easily check the benchmarking charge database (New York uses the FAIRHealth charge database) before the claim is paid. Thus, no one – not the patient, provider, or insurer – is wasting money disputing reasonable small noncontroversial claims. Similarly, in Texas, provider’s charges are paid when the claim is under $500.

6. **Require Insurers to Pay Allowed Amounts Directly to the Provider**

Collecting the patient’s cost-sharing amount for emergency care – whether it be copays, coinsurance, or deductibles – is a particularly difficult problem for both patients and providers. In most outpatient settings, the provider collects the copayment before providing care. However, patients receiving emergency care are often not in a condition to prepay and EMTALA restricts providers from collecting prepayments. So, emergency providers must track down these often small payments long after the care is provided. This often leads to bad debt and further erosion of physician reimbursement. Moreover, clinicians often do not know what the in-network cost-sharing is while health plans have access to this information. So, the payment transaction is best effectuated between the insurer and patient. The legislation could address this problem by requiring the insurance company to pay emergency providers all allowed amounts directly. We recommend that this include the patient’s copay, coinsurance and the portion of the deductible the insurer has applied to the claim. Moreover, patients significantly benefit when they are removed from any payment disputes between providers and insurers. Therefoere, **we urge you to require insurers to pay allowed amounts directly to the provider.**

Further, we urge you to **clearly define the term “allowed amounts” to:**

- Include all out-of-network allowed amounts, including data from ERISA plans,
- Include all patient cost-sharing including copays, coinsurance, and the portion of the deductible that the insurer applied to the claim, and
- Exclude In-Network Allowed Amounts.

As described earlier, in emergency care, in-network rates do not reflect market rates because EMTALA has eviscerated the provider’s negotiating power. Moreover, in-network rates are typically discounted below market rates in return for some other benefit such as quicker payment, assignment of benefits, reduced administrative cost, etc. Some contracts also include bonus payments that are not captured in the in-network rate. Other contracts are based on blended rates that combine Medicaid, Medicare and Commercial rates. It would not be appropriate to water down out-of-network allowed amounts with these in-network rates.

However, we understand that some databases currently include in-network rates in their calculation of “allowed amounts.” This data bias could be addressed by adjusting those
numbers by either removing the in-network data from the calculation or using an applicable adjustment formula.

7. **Apply the Federal Standard Unless the State Standard is Sufficiently Unambiguous and Enforceable and Improves Patient Access to Emergency Care**

The discussion draft would require the insurer to pay “an amount determined, and payable in such manner, in accordance with the law of the applicable State, county, parish, or tribal government.” Unfortunately, this provision, which provides for state preemption, raises a number of questions and concerns. **We urge you to clarify that state laws will not preempt the federal minimum benefit standard unless the state law is unambiguous, enforceable, and improves patient access to emergency care.**

Here are a few state laws that illustrate the need for this provision:

In Mississippi, Illinois, California, and New Mexico, balance billing is either banned or limited in certain circumstances, yet those states have not set a minimum benefit standard for emergency care. New Jersey has established an arbitration system for disputes over $1000, but has not established an MBS or dispute resolution process for smaller bills and disputes.

New Hampshire requires out-of-network reimbursement at a “commercially reasonable value.” And a number of bills under consideration in a number of other states (such as Washington) would use a similar standard. However, this “standard” is so ambiguous as to be unenforceable.

In Missouri, arbitration awards can be as low as 120% of Medicare. This standard is unreasonably low and threatens access to emergency care.

In a 2016 Florida law, the MBS was set at “usual, customary physician charges in the community,” yet the standard has not been further defined or enforced by regulators. So, despite the clear statutory intent, insurers are reimbursing at rates as low as Medicare rates.

In all of these states we believe both the federal and state MBS should apply.

There are also states, like Texas and Alaska, that have thoughtfully considered the issue of balance billing and decided to set a minimum benefit standard but have also decided not to ban balance billing. This creates its own set of federal preemption problems because the state minimum benefit standard does not reflect an environment where balance billing is banned. Those legislators may well have set a higher MBS if balance billing were banned. Furthermore, any federal balance billing prohibition must be predicated on a fair and transparent physician charge-based minimum benefit standard.

8. **Require Insurers to Disclose to Patients and Providers Their Out-of-Network and In-Network Allowed Amounts and Formulas**

One of the main reasons that the current greatest-of-three rule does not work is that the insurers are able to manipulate and calculate reimbursement in secret and providers cannot figure out if payments comply with the law. There are complicated procedures that a patient can follow in order to view certain in-network and out-of-network reimbursement information. However, those procedures are not open to providers. As members of a task force focused on transparency,
we encourage you to add a provision to the bill that will ensure that information on in-network and out-of-network formulas and reimbursement rates are easily and inexpensively disclosed to patients, providers, and regulators.

9. **Require Insurers to Disclose the Type and Location of the Plan on the Members’ Insurance Card**

In addition, there is a simple transparency requirement that would significantly reduce regulatory burdens on providers. **We ask you to require insurance companies to disclose the type of plan on the insurance card as well as the state where the plan is located.** A very different set of federal and state patient protections apply to different types of plans. ERISA plans, ACA plans, grandfathered plans, Medicaid MCO plans, and Medicare Managed Care Plans all have a different set of applicable laws and applicable patient protections (see Attachment 4). Providers handle claims from a wide variety of insurers and those insurers offer a wide variety of plans. Providers should be able to easily determine what type of claim – and therefore which patient protections – apply to the claim so they can ensure appropriate compliance. Furthermore, it should be clear which state laws apply. For instance, insurers could simply indicate ERISA plans by adding a “-E” to the end of those policy numbers. This requirement should be uniform across all commercial payors and all plans administered by those payers.

10. **Require Insurers to Appropriately Disclose and Comply with the Federal Prudent Layperson Standard**

When the federal government established the greatest-of-three rule protecting coverage of emergency care, it simultaneously extended the federal prudent layperson (PLP) standard to all commercial plans and issuers that cover emergency care (except plans grandfathered from ACA requirements). Unfortunately, a number of commercial insurers have been violating the federal PLP standard. So, **we ask that you ensure that commercial payers comply with the federal PLP standard by (1) reiterating some of the key aspects of the federal prudent layperson in the bill and (2) requiring that commercial insurers appropriately disclose the PLP standard to their insureds.**

Over the years, the Centers for Medicare & Medicaid Services (CMS) has written numerous letters clarifying the federal Prudent Layperson Standard and they clearly provide that

- Insurers cannot deny or down code emergency claims based solely on symptom or diagnosis lists, and
- Insurers cannot deny emergency claims as nonemergent without first reviewing the medical record.

This makes sense as the PLP standard is based on the prudent layperson’s concerns when they visit the emergency department. The insurer cannot use the final diagnosis to retroactively go back and raise questions about the patient’s frame of mind.

Further, insurers, such as Anthem, have been sending misleading messages to their insureds which misconstrue the prudent layperson standard and likely scare patients away from seeking appropriate care in the emergency department. For instance, insurers have informed their insureds that they will not cover nonemergency care provided in the emergency department.
However, the insurer hasn’t clarified that “false alarms” clearly meet the definition of an “emergency.” If a prudent layperson would be concerned they may be experiencing a life-threatening event, then it is an emergency - even if the final diagnosis is a minor one. So, due to these messages, patients who are appropriately concerned that they are experiencing a life-threatening event likely believe they should self-diagnose themselves first and avoid the emergency department unless they are 100% sure it is a life-threatening event. As a group interested in transparency and patient protections, we encourage you to require appropriate disclosures to patients and specifically prohibit messaging in way that could mislead patients about the PLP standard and their coverage.

11. **Delete Provisions that Limit Post-Stabilization Care**

We share your interest in helping patients understand out-of-network pricing information prior to receiving nonemergency care. We think the appropriate entity to provide education on coverage is the insurer. If emergency providers were required to stop treating a patient at the moment of stabilization, in order to allow the hospital to discuss potential costs, it likely would cause significant barriers to patient care and increase costs for all. Further, it could violate EMTALA, the PLP Standard, and more.

For instance, if a patient were to visit the emergency department for a potential heart attack that ends up being heartburn, do you want the provider sending the patient to a hospital administrator to discuss costs before the physician discusses the diagnosis and treatment of heartburn and prescribes medicine? Similarly, what if an emergency physicians determines midway through suturing a cut that the patient is now stabilized, yet the physician chooses to finish suturing the injury. Will the entire encounter be covered by the insurer?

Furthermore, “stabilization” is not a clear and specific moment in time. In fact, providers often look back at an event to retroactively determine when the patient was stabilized. And a patient who is medically stable is not necessarily ready to discuss out-of-network costs. What if the person is medicated, asleep, or traumatized? Therefore, we do not believe the moment of stabilization should not be the trigger to discussing costs.

Moreover, in an emergency situation, it is often difficult to determine if the emergency patient is insured and by whom because EMTALA requires providers to ignore the patient’s insurance status until after the visit is complete.

Therefore, we urge you to delete section 5.

C. **CONCLUSION**

As you consider suggested improvements to the discussion draft, please keep in mind that the legislation would impact both out-of-network and in-network reimbursement. If out-of-network reimbursement is set too low, insurers will not invite emergency physicians into their networks at fair and sustainable rates. Thus, more patients would be responsible for the cost of care through their deductible. Banning balance billing is a noble objective we can support if it is predicated on a defined, objective minimum benefit standard tied to a percentile of physician charges. However, the more pressing issues are inadequate nonmarket-based contract rates and the effects of cost-shifting. The discussion draft, which should be part of a broader conversation we openly
welcome, fails to recognize that 2 of 4 patients seen in a typical emergency practice are covered by an insurance product (or no insurance at all) that reimburses the provider below costs, further necessitating the need for sustainable cross-subsidizing through commercial contract rates.

Emergency medicine is the jewel of the healthcare system and emergency providers are honoring their commitment to EMTALA by delivering a disproportionate share of uncompensated and undercompensated care. Federal law must ensure that the healthcare safety net is not jeopardized by an insufficient Minimum Benefit Standard that can be unilaterally manipulated by insurance companies in a manner that drives down both out-of-network and in-network reimbursement rates.

The EDPMA appreciates the opportunity to share our concerns and provide suggestions. Please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

Sincerely,

[Signature]

Andrea Brault, MD, FACEP, MMM, Chair of the Board
Emergency Department Practice Management Association (EDPMA)

attachments
Attachments
Analysis Shows That Health Plans Transfer Billions of Dollars in Liability for Out-of-Network Emergency Care Claims to Enrollees

Prior to enactment of the Patient Protection and Affordable Care Act (ACA), most health plans used a well-established method to determine the benefits for enrollees for emergency care services provided by out-of-network (OON) physicians. This method usually relied on a usual and customary charge database, and the plans typically paid a benefit equal to the lesser of the provider’s full charge or the 70th to 80th percentile of usual and customary charges for a particular geographic area.

The ACA establishes a number of “patient protections” including requirements that health plans and health insurance issuers which provide any benefits for emergency services in an emergency department (“ED”) of a hospital must cover emergency services without regard to whether a particular health care provider is an in-network provider, and generally cannot impose any copayment or coinsurance for such OON provider services that is greater than what would be imposed if the services were provided in network.

The ACA also prohibits insurers from applying prior authorization for ED services that would be performed by OON providers, as well as prohibiting any other requirements or limitations on OON emergency services that are more restrictive than the requirements or limitations that apply to ED services furnished by in-network providers.

The Department of Health & Human Services (HHS) implemented the ACA’s OON emergency services coverage requirements as a part of a June 2010 regulation. As a part of this rule, HHS established a “greatest of three” methodology for determining payment rates for OON emergency services. HHS in the regulation, stated the importance of specifically not transferring significant financial liability to the enrollees: “It would defeat the purpose of the protections in the statute if a plan or issuer paid an unreasonably low amount to a provider, even while limiting the coinsurance or copayment associated with that amount to in-network amounts.”

The “greatest of three” methodology essentially provides that an insurer satisfies the ACA’s OON emergency services coverage requirements if it provides OON emergency services benefits equal to the greatest of:

1. The median in-network payment rate for the ED service;

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1 75 Fed. Reg. 37188, 37194 (June 28, 2010).
2 Id.
3 Id.
(2) The amount that the plan generally uses to determine payments for OON services (such as usual, customary, and reasonable charges); or

(3) The Medicare payment rate for the ED services.

During the public comment period on these regulations, the American Medical Association (AMA), the American College of Emergency Physicians (ACEP), and many other medical societies expressed concern about these requirements because they relied on: (1) unpublished, confidential contract rates; (2) Medicare rates, which have no relationship to the reasonable commercial value of the services; and (3) rates that were arbitrarily established by the plans. In short, the standard for these benefits not only is unfair to providers and enrollees, but also is non-transparent, unenforceable, and susceptible to defeating the overall purpose of this ACA patient protection, which is to limit the financial liability for OON ED care.

In most instances, insurers base OON emergency services payments on the second methodology. Beginning in 2013, health plans began to abandon the use of a usual and customary charge database, and instead began calculating these payments on totally arbitrary rates, either ignoring the patient protection standards in the ACA, or using their own favorable interpretation of these standards to justify these greatly reduced provider payments. As a result, instead of payments that covered most OON emergency care claims in full, the plans began to make greatly reduced payments and transferred the liability for these claims on to the backs of unsuspecting enrollees.

ACEP analyzed the claims database of one of the largest national emergency physician billing companies. The claims in this database represent approximately seven percent of emergency physician claims submitted nationally. The analysis focused on claims submitted to two national health plans in 2013. Consisting of over 200,000 claims from across the country, these claims are believed to be representative of the health insurance industry in general.

The analysis shows that both plans had substantially lowered the benefits to their enrollees for OON emergency physician services during 2013. Payments from one plan decreased by an average of $61. Payments from another plan decreased by an average of $325. ACEP then extrapolated the underpaid claims from these plans across all commercial OON emergency physician claims covered. It would appear that these two plans alone represent an annualized transfer of more than $575 million dollars in liability for OON emergency physician claims.

Since this analysis did not include benefits for the claims of emergency department on-call specialists or the claims of hospitals for emergency department facility charges, which have experienced similar reductions; ACEP believes that these plans actually have transferred several billion dollars in liability on to their enrollees for this care. As these two insurers roll out their payment reduction strategy to more claims, and as other
insurers adopt this strategy, the financial liability transfer numbers will increase significantly. This unprecedented transfer of liability from plans to enrollees for OON emergency care services, benefits that enrollees and employers have paid for through insurance premiums, thwarts the ACA patient protections and threatens the financial wellbeing of enrollees and the financial viability of the emergency care safety net.
Attachment 2
Uses the 80th Percentile from the following FAIR Health Medical products:

- FH\textsuperscript{*} Medical – November 2015
- FH\textsuperscript{*} Medical – May 2016
- FH\textsuperscript{*} Medical – November 2016
- FH\textsuperscript{*} Medical – May 2017
FH® Medical 80th Percentile ER Visit Values in New York

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>November 2015</th>
<th>May 2016</th>
<th>November 2016</th>
<th>May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>EMERGENCY DEPARTMENT VISIT LIMITED/MINOR PROB</td>
<td>$120</td>
<td>$115</td>
<td>$117</td>
<td>$128</td>
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<tr>
<td>99282</td>
<td>EMERGENCY DEPARTMENT VISIT LOW/MODER SEVERITY</td>
<td>$216</td>
<td>$213</td>
<td>$220</td>
<td>$215</td>
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<tr>
<td>99283</td>
<td>EMERGENCY DEPARTMENT VISIT MODERATE SEVERITY</td>
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<td>$400</td>
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<td>$410</td>
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<tr>
<td>99284</td>
<td>EMERGENCY DEPARTMENT VISIT HIGH/URGENT SEVERITY</td>
<td>$664</td>
<td>$702</td>
<td>$763</td>
<td>$800</td>
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<tr>
<td>99285</td>
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<td>$1,004</td>
<td>$1,211</td>
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</table>

Uses the 80th Percentile from the following FAIR Health Medical products:

- FH® Medical – November 2015
- FH® Medical – May 2016
- FH® Medical – November 2016
- FH® Medical – May 2017
Attachment 3
Medicare is keeping up neither with medical inflation nor with private insurance.

**Illustrative Comparison of Medicare Prices for Physicians' Services under Current Law, the Projected Baseline, and H.R. 2 relative to the MEI**

![Graph showing the comparison of Medicare prices under different scenarios.]


**Figure 2. Illustrative comparison of relative Medicare, Medicaid, and private health insurance prices for physician services under current law**

![Graph showing the comparison of prices under different years.]

*Source: Office of the Actuary, Centers for Medicare and Medicaid Services Memorandum on *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers (June 8, 2018).*
Attachment 4
**Problem:** Insurers typically do not disclose the type of plan that covers a claim. So, patients and providers cannot determine which federal protections apply to the visit. For instance, patients don’t know if certain annual and lifetime limits apply to their required contribution. And providers don’t know whether the federal minimum payment standard for emergency care applies. Patients and providers may need to expend a great deal of time, energy and money to gather this simple, yet essential, plan information.

**Request:** Federal legislation and regulations should require transparency by requiring healthcare insurance policy numbers to designate the type of plan. For instance, if policy numbers included a "-E" at the end when it is an ERISA plan, this would clear up a lot of confusion.

The following chart shows that many important federal laws that are applicable to emergency care apply to some, but not all, types of policies:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Definition of Emergency Care</th>
<th>Coverage of Emergency Care</th>
<th>Patient Contribution to Emergency Care</th>
<th>Insurer Contribution to Emergency Care</th>
<th>GOT Formula Disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid (non-MCO)/Medicaid MCO (35% of ED claims)</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medicare/Medicare Advantage (18%)</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>ERISA Plans (self-insured plans) (21%)</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Group Market (&lt;14%)</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>?</td>
</tr>
<tr>
<td>Individual Market (&lt;14%)</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ACA Exchange Plans (&lt;14%)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>?</td>
</tr>
<tr>
<td>Grandfathered Plans (&lt;14%)</td>
<td>X</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>