American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

June 25, 2019

Senator Lamar Alexander
Chairman
Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, D.C. 20510

Senator Patty Murray
Ranking Member
Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Alexander and Ranking Member Murray,

On behalf of the American College of Emergency Physicians (ACEP) and our 38,000 members, we would like to express our strong opposition to Title I of S. 1895, the "Lower Health Care Costs Act," which uses the fundamentally flawed benchmarking mechanism in its attempt to resolve surprise medical bills.

As we have discussed with you and the Health, Education, Labor and Pensions (HELP) Committee staff on numerous occasions over the past year, we strongly support protecting patients from surprise medical bills using a mechanism that not only takes them out of the middle, but *also* ensures the federal government will neither price-set nor negatively influence negotiations between two private parties. We firmly believe benchmarking is the wrong approach to resolving this issue. It will negatively affect all future contracting negotiations, both in- and out-of-network, and will quickly lead to reduced access to emergency physicians and other on-call specialists, especially in rural communities.

ACEP instead calls for a proven, true "baseball-style" independent dispute resolution approach to ensure a fast and fair resolution of any billing issues between insurers and providers. This simple and efficient process has effectively incentivized providers to charge reasonable rates and insurers to pay appropriate amounts in several states. In New York, this model serves as an effective backstop, curbing the number of surprise bills without raising provider costs or insurer premiums, and resulting in only *0.0113 percent of all emergency claims* in the state even being brought to arbitration in 2018. And contrary to some claims, the actual costs of independent dispute resolution are minimal (only $200 to $300). Furthermore, these costs are borne by the losing party, which is another incentive to reach an equitable compromise before it even reaches this point in the dispute.

As work continues on this legislative proposal, we urge you to keep in mind the particular factors that are unique to emergency medicine. In the emergency department (ED), minutes and seconds matter and emergency physicians are often required to exercise

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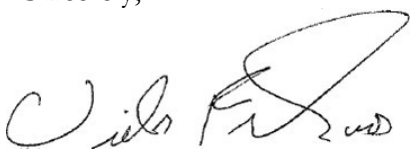
their best clinical judgement quickly. Additionally, emergency physicians and their practice of medicine are subject to the Emergency Medical Treatment and Labor Act (EMTALA) that guarantees access to emergency medical care for everyone, regardless of insurance status or ability to pay. This law – an important consumer protection – has had the unintended consequence of disincentivizing health plans from entering into fair and reasonable contracts to provide services at reasonable in-network rates.

Because emergency physicians must screen and stabilize any patient who comes into the emergency department, insurance companies are ensured their policyholders are always able to access care in that setting and so 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 shifts the majority (if not the entirety) of the cost of the encounter to the patient, rather than the insurer.

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.

Once again, we urge you to use the thoughtful, bipartisan framework developed by the Senate Price Transparency Work Group as the starting point in Title I of S. 1895, instead of benchmarking. With appropriate modifications, this would serve as the best foundation to protect patients from surprise medical bills.

Sincerely,



Vidor E. Friedman, MD, FACEP
ACEP President