September 5, 2019

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

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

The Honorable Bobby Scott
Chairman
Committee on Education and Labor
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Virginia Foxx
Ranking Member
Committee on Education and Labor
2101 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Neal, Ranking Member Brady, Chairman Scott, and Ranking Member Foxx:

As your committees consider a legislative solution to protect patients from surprise medical bills, we urge you to keep in mind how unintended consequences of congressional action could severely affect small emergency physician practices, threaten access to health care for our patients particularly in rural and underserved communities, and further distort incentives for insurers to negotiate fairly with smaller groups like ours. We strongly share the Committee's desire to take patients out of the middle of billing disputes between insurers and providers, and we are grateful for the opportunity to share the perspective of small emergency physician groups that comprise a significant portion of the overall practice of emergency medicine in the United States.

The undersigned 60 groups are smaller, independent practices that serve anywhere from one to several hospitals, and in total provide lifesaving emergency care for 7.3 million patients per year in small rural communities and large urban centers alike. Small businesses play an important role in the economy of our nation and the local communities we serve. And just like countless other small businesses providing thousands of jobs throughout our country, we face challenges such as ensuring our long-term stability, providing for our employees, and meeting overhead costs, among many others.

As emergency physicians, our practice is subject to the Emergency Medical Treatment and Labor Act (EMTALA), which guarantees that we provide patients with emergency medical care regardless of their insurance status or ability to pay. Unfortunately, health plans have manipulated this important consumer protection to avoid entering into fair contracts to allow us to provide our care at reasonable in-network rates. This affects all physicians providing care under EMTALA, but the full effects have a disproportionate impact on smaller groups like ours.

Small groups already operate at a disadvantage with health plans, a problem that has only grown in light of insurer consolidation and single-insurer dominance in many states. No experience is

identical, but many small groups already face "take-it-or-leave-it" contract offers from insurers, and in some cases, do not even have their calls returned in their attempts to enter contract negotiations. The market is already skewed in favor of large health plans, and the smaller the physician group, the less incentive there is for these plans to negotiate fairly.

We are deeply concerned by some proposals in Congress that would further exacerbate the issues we already currently face in attempting to negotiate contracts with insurers, and ultimately, would drive more small groups like ours out of the market entirely. This would lead to increased consolidation, reduced competition, and higher costs throughout the health care system. Most importantly, it would negatively affect our patients' access to the emergency care they need and deserve. Like you, we share the goal of addressing bad actors – both insurers and providers – but we are alarmed by proposals that, to date, have not seemed to take into account how the thousands of emergency physicians practicing in small groups would be affected by various legislative proposals under consideration.

One of the approaches that has been considered by Congress is the establishment of a benchmark payment for out-of-network care at the median in-network rate, as determined by an insurer for each specific insurance product. Notwithstanding the inherent lack of transparency into these proprietary, "black box" numbers, this rate is problematic because it provides insurers with access to a discounted contract rate *without* providing physicians with the corresponding benefits of contracting in exchange. Further, this benchmark rate would effectively become the new cap for in-network contracts in a geographic area, leading to a downward spiral in future contracts across the board.

Health plans benefit in any scenario under this proposal. An insurer can simply offer a "take-it-or-leave-it" in-network rate, offering to pay physicians less for their services in order to simply pay less or to discourage them from entering a contract. Then if physicians choose not to accept such contracts, the insurer also benefits as patients will be forced to pay more out-of-pocket before their coverage kicks in, especially as deductibles for out-of-network care continue to rise.

Large health plans already hold significant leverage over small physician groups, and combined with the EMTALA mandate and the significant amounts of uncompensated and undercompensated care we provide, this approach would further disincentivize insurers from ever negotiating with small groups. Instead, it encourages them to further narrow their networks, which only further serves to disadvantage our patients. This is not just a theoretical outcome – in California, where the state opted for a similar benchmark approach, insurers immediately began to terminate longstanding contracts or offered to renegotiate at steeply reduced rates in hopes of pushing more physicians out of network.

Instead, we strongly urge you to consider an independent dispute resolution (IDR) process as the most fair and effective solution to the problem of surprise billing. As evidenced by New York's experience with IDR, this "baseball-style," loser-pays approach has had the intended effect of eliminating surprise bills without disrupting negotiations between insurers and physicians, or providing one side with an unfair market advantage. While the New York law is still relatively

new, several years of data now provide compelling evidence that this approach works and is not burdensome or costly, as some detractors had initially suggested. In fact, the New York law has served as the basis for several other states, including Texas, which recently amended its own surprise billing law to more closely resemble the successful New York model. We believe this process could be feasibly scaled to the federal level without adding undue burdens or costs to taxpayers.

While the Energy and Commerce Committee added an IDR amendment in its own surprise billing package, as written it would effectively lock out 99 percent of care provided by emergency physicians from the dispute resolution process. Establishing a qualifying threshold of $1,250 based on the insurer's allowed amounts renders this process as "IDR in name only" for virtually every emergency physician no matter what size group they are a part of. But especially for small groups like ours, this language effectively puts any equitable dispute resolution process firmly out of reach. While the addition of IDR was a critical first step, significant changes are still needed to ensure that this process can be initiated by small groups. A necessary first step would be to substantially lower the threshold and to allow batching of similar claims within a reasonable time period to meet the threshold, as many small groups in particular simply may not have the necessary volume needed to meet the threshold.

Again, as a critical part of the nation's health care safety net, we strongly urge you to consider how federal policies may have an outsized impact on the small groups that provide care to American patients. As you continue to develop legislation to address this important issue, we appreciate your thoughtful approach and offer our assistance and experience to you and your staff. We firmly believe an appropriate policy can be crafted in a way that sufficiently addresses outliers and bad actors without fundamentally disrupting negotiations between physicians and insurers who attempt to negotiate in good faith. Thank you once again for the opportunity to share our concerns.

Sincerely,

Allied Emergency Physicians	Simi Valley, CA
Antelope Valley Emergency Medical Associates	Lancaster, CA
Associated Emergency Physicians	Renton, WA
Augusta Emergency Physicians	Fishersville, VA
Banner Nevada West	Fallon, NV
Berkeley Emergency Medical Group, Inc.	Oakland/Berkeley, CA
Burbank Emergency Medical Group, Inc.	Burbank, CA
Carolina Mountain Emergency Medicine PA	Asheville, NC
Cascade Emergency Physicians	Auburn, WA
Central Emergency Physicians	Lexington, KY
Chesapeake Emergency Physicians	Chesapeake, VA

Code 3 Emergency Centers	Frisco, TX
Commonwealth Emergency Physicians	Leesburg, VA
Commonwealth Emergency Physicians Mount Vernon	Alexandria, VA
Community Emergency Medicine Partners	Centerville, OH
Core Clinical Partners	Atlanta, GA
Doctors for Emergency Service	Wilmington, DE
DuPage Emergency Physicians	Downers Grove, IL
East Central Iowa Acute Care, LLP	Cedar Rapids, IA
ECEP II, PA	Wilmington, NC
Eden Emergency Medical Group	Castro Valley, CA
Elite Emergency Physicians, Inc.	Elkhart, IN
Emergency Medical Associates of Tampa Bay	Tampa, FL
Emergency Medicine Specialists	Milwaukee, WI
Emergency Physicians of Central Florida LLP	Orlando, FL
Emergency Physicians of the Rockies	Fort Collins, CO
Emergency Physicians Professional Association (EPPA)	Bloomington, MN
Emergency Resources Group	Jacksonville, FL
EmergiTrust	Franklin, TN
ERMED, SC	Milwaukee, WI
ESPMA - Emergency Specialists Physician Medical Associates	Torrance, CA
Farmington Emergency Medicine Associates, PLC	Farmington Hills, MI
Georgia Emergency Department Services	Gainesville GA
Grand River Emergency Medical Group, PLC	Grand Rapids, MI
Hawaii Emergency Physicians Associated	Kailua, HI
Lalor Allen	Asheville, NC
Lancaster Emergency Physicians	Lancaster, PA
Long Beach Emergency Medical Group	Long Beach, CA
Madison Emergency Physicians	Madison, WI
Metro Emergency Physicians	Kansas City, MO
Mid-Atlantic Emergency Medical Associates, PLLC	Charlotte, NC
Mills Peninsula Emergency Medical Associates	Burlingame, CA
Monterey Bay Emergency Physicians	Monterey, CA
Mountain Emergency Physicians	Hickory NC
Napa Valley Emergency Medical Group	Napa, CA

Northern Nevada Emergency Physicians	Reno, NV
Olympia Emergency Services PLLC	Olympia, WA
Pacific Emergency Providers, APC	San Diego, CA
Pinnacle Emergency Physicians of Bakersfield	Bakersfield, CA
SEP	Spokane, WA
Sound	Bakersfield, CA
Sound Emergency Physicians of Kansas	Topeka, Kansas
Sound Physicians	Reno, NV
Sound Physicians-Aiken Regional Med Center	Aiken, SC
South Coast Emergency Medical Group	Santa Barbara CA
St. Vincent Emergency Physicians	Indianapolis, IN
Sussex Emergency Associates	Lewes, DE
Wake Emergency Physicians, PA	Wake County, NC
Wake Forest Emergency Providers	Greensboro, NC
Williamsburg Emergency Physicians, Inc	Williamsburg, VA