

December 10, 2019

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

The Honorable Frank Pallone  
Chairman  
House Energy & Commerce Committee  
2125 Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Greg Walden  
Ranking Member  
House Energy & Commerce Committee  
2322 Rayburn House Office Building  
Washington, D.C. 20515

Dear Chairman Alexander, Chairman Pallone and Ranking Member Walden:

On behalf of the American College of Emergency Physicians (ACEP) and our 38,000 members, I am writing to regretfully express our opposition to Title III of the newly-released proposal for the “Lower Health Care Costs Act of 2019”, as currently written. ACEP strongly shares Congress’s commitment to protect patients from surprise bills, and has worked [tirelessly over the past two years](#) to help inform legislative efforts in a constructive and collaborative manner. However, it appears much of this input has gone unheeded, and to our disappointment we are yet again unable to endorse your proposal given the severe consequences it would have for patient access to emergency care and the broader health care system as a whole.

Key to our opposition is the damaging impact that would occur if several provisions of this new proposal were to be implemented. These include the:

- **Threshold for Independent Dispute Resolution (IDR):** While we appreciate the threshold being lowered from the original \$1,250 included in H.R. 3630 as passed, to \$750, utilizing the median in-network amount at this level remains far too high and would disqualify virtually all emergency physician claims. In order to ensure all claims are fairly adjudicated and patient access to emergency care is preserved, the qualifying threshold for IDR should be eliminated entirely. Recent informal estimates calculated by the Congressional Budget Office have demonstrated that eliminating a qualifying threshold for IDR would have only minimal impact on a score.
- **Median in-network benchmark:** The proposal continues to set the insurer’s payment at the median in-network rate. Insurers will now have no reason to contract with physicians because they will have access to a discounted contract rate without needing to provide any of the usual corresponding benefits in exchange. Coupled with our obligations to provide care under the Emergency Medical Treatment and Labor Act (EMTALA), insurers will no longer have any incentive to fairly contract with emergency physicians to bring us into their networks. A more workable approach would be to have a commercially reasonable initial payment – as determined by the insurer – with a robust and accessible “loser pays” IDR mechanism that incentivizes fair payments and charges by either party.
- **90-day “cooling off” period:** This provision as currently drafted could leave either party exposed to unreasonable payments or charges for that service for 90 days following a determination by the arbiter, thereby inviting abuse. Therefore, it should be eliminated altogether or, at a minimum, modified to require the arbiter’s determination to at least apply for all claims in the subsequent 90 days for that same service, provider, and insurer. Such a modification would protect all parties.

WASHINGTON, DC OFFICE

2121 K Street NW, Suite 325  
Washington, DC 20037-1886

202-728-0610  
800-320-0610  
[www.acep.org](http://www.acep.org)

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Despite these problems, we do appreciate some improvements that have been included in your latest proposal. The requirement for insurers to print deductible amounts on their ID card would be especially helpful in clarifying for policyholders the true amount of cost-sharing they will be personally liable for should they require care under their coverage. As well, having the benchmark changed from 2019 overall median in-network amounts to those on January 31, 2019 will reduce the gaming of median amounts by insurers that had already started by this past summer. Further, tying this median in-network amount to the rate for all commercial insurers in that area rather than just for that insurer (as was done in H.R. 3630) will be more reflective of the actual market in that provider's geographic area.

While a step in the right direction, these small improvements are not nearly enough to mitigate the untold damage that would occur to our nation's emergency medicine safety net of care should Title III of the Lower Health Care Costs Act of 2019 be implemented as currently drafted. Rural areas will continue to be hardest hit, with further hospital closures as it becomes increasingly more difficult for them to maintain adequate medical staffing. Additionally, by eliminating what few incentives remain for insurers to negotiate fairly with physician groups, the growing trend of consolidation within health care will be exacerbated, further increasing costs of care. In combination, these effects and others will significantly threaten access to high quality, affordable care for patients across the nation.

As frontline healthcare providers, we remain committed to protecting patients from surprise medical bills. That said, for them to be truly protected, the right approach must be carefully and thoughtfully developed with input from relevant stakeholders and then given full consideration. Patients deserve a cure, not a band-aid, for surprise billing.

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 that reads "William P. Jaquis". The signature is written in a cursive, flowing style.

William P. Jaquis, MD, MSHQS, FACEP  
ACEP President