



June 5, 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, thank you for your efforts to protect patients and their families from unexpected high medical bills and to increase access to affordable health care services. ACEP remains committed to the goal of resolving the issue of surprise medical bills in a constructive and substantive manner, and we appreciate the opportunity to provide comment on your Discussion Draft of legislation intended to address this and important issues surrounding health care costs. **Yet we have strong concerns with the legislative draft as currently written.**

Patients cannot choose where or when they will need emergency care, and they should not be punished financially for having emergencies. ACEP strongly agrees that patients must truly be taken out of the middle of billing issues that can arise around insurance coverage of emergency care.

As work continues on this legislation, 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 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 effect of disincentivizing health plans from entering into fair and reasonable contracts to provide services at reasonable in-network rates.

Because emergency physicians are required to screen and stabilize any patient who comes into the emergency department (under EMTALA), insurance companies are ensured their policyholders are always able to access care there. Therefore, they 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

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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 then 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.

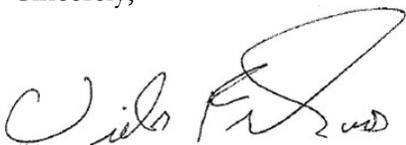
We agree strongly that more must be done to protect patients and their families from unexpected high medical bills and provide greater stability and transparency in these encounters. **However, we believe that the Discussion Draft, as written, will not achieve these essential goals.** Primarily, the three options listed to address out-of-network (OON) billing disputes between providers and insurers all fail to provide a fair and market-driven reimbursement amount to providers that is needed to preserve access to vital, life-saving services. In fact, two of the options are essentially identical: benchmarking to median contracted rate and "arbitration" pegged to median contracted rate along with a high exemption amount. With respect to the latter option, many emergency physician claims would fall under the exemption amount, meaning that the physicians would only be paid the median contracted rate.

ACEP instead calls for a proven, true 'baseball-style' arbitration 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 has curbed the number of surprise bills without raising costs or premiums and resulted in only *0.000113 percent of all emergency claims* in the state even being brought to arbitration in 2018.

Please find below our more detailed comments regarding this draft legislation. We stand ready to work with you and the members of the Committee to develop a more impactful and meaningful bill that protects our patients and their access to high quality emergency care.

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,

A handwritten signature in black ink, appearing to read "Vidor E. Friedman". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Vidor E. Friedman, MD, FACEP
ACEP President

TITLE I: ENDING SURPRISE MEDICAL BILLS

Section 101 – Protecting Patients Against Out-of-network Deductibles in Emergencies

Because emergency physicians are required to screen and stabilize any patient who comes into the emergency department (under EMTALA), insurance companies are ensured their policyholders are always able to access emergency care. Therefore, they 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.

Current law (under section 2719A of the Public Health Service Act) requires patient cost-sharing to be the same for in- or out-of-network emergency care, but it defines cost-sharing in that section as **only the copay and coinsurance**—*not* the deductible. Insurers are therefore further incentivized to keep their networks narrow since if a policyholder’s emergency care happens to be OON, the patient’s deductible is likely significantly higher, which then shifts the majority (if not the entirety) of the cost of the encounter to the patient, rather than the insurer. 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.

We are therefore pleased that the Discussion Draft would now recognize deductibles as cost-sharing for emergency care, so that patients’ cost-sharing will truly be no higher for OON emergency care than if that care had been provided in-network. When facing an emergency, patients or their family members do not have time to try and figure out where their care will be in-network, so they should not be punished financially for being unable to do so. Leveling these deductibles whether the emergency patient is in- or out-of-network will increase the incentive for insurers to negotiate fairly with emergency physician groups who seek to go in-network.

More can be done, though, to protect patients. Plans or issuers should be required to specify their insurance product on the policyholder’s ID card so that it is clear to both the patient and treating providers. While a simple step, this can help patients better understand the limits of their insurance coverage and reduce the surprise when they later get a bill. For scheduled care, this information can greatly facilitate providers being able to assist patients at the point of care with navigating their coverage and benefits and more specifically provide out-of-pocket pricing estimates. As well, for both emergency and scheduled care, having this information recorded in a patient’s record can help the provider resolve billing and cost-sharing issues and potential disputes on the patient’s behalf, keeping the patient fully out of the middle.

ACEP also appreciates that the Discussion Draft updates Section 2719A(b) of the Public Health Service Act (PHS) to include freestanding emergency rooms. However, we believe the term “room” should be replaced with “centers” both here and in all other locations within the legislation.

ACEP agrees that freestanding emergency centers (FSECs) should be held to the same standards and requirements as hospital-based EDs. We believe that all EDs should meet certain criteria including being available to the public 24 hours a day, seven days a week, 365 days per year, have policy agreements and procedures in place to provide effective and efficient transfer to a higher level of care if needed, and follow

the intent of the federal EMTALA statute. This would ensure that all individuals presenting at an FSEC would be provided an appropriate medical screening exam and, if necessary, be provided with stabilizing treatment within the facility's capability or transferred to an appropriate other facility for definitive care. FSECs should also have equivalent standards as hospital-based freestanding emergency departments for quality improvement and governance.

Section 102– Protection Against Surprise Bills

Section 102 makes further modifications to Section 2719A of the PHS. The newly added subsection (f) would set notice and consent and other requirements for how subsequent OON care would be covered for patients who are admitted to a hospital following care in its emergency department. ACEP has concerns with the requirements as currently drafted.

We appreciate the Discussion Draft's effort to attempt to align the language of EMTALA (and existing Section 2719A of the Public Service Act) to questions related to cost sharing, billing and payment rules. The Committee was wise to recognize that an emergency patient who is treated by an OON provider, then admitted as an inpatient, may still lack the mental wherewithal to make a meaningful election regarding consenting to further OON treatment or electing to move to an in-network facility or provider.

However, we have two major concerns: 1) stabilization is the wrong barometer for triggering notice and consent to further OON treatment; and 2) any notice and consent requirements should be placed upon the only entity with the relevant information which is the insurer, not the providers.

The Discussion Draft creates an elaborate and burdensome process by which the *provider* must make a judgment regarding the patient's level of mental awareness to receive and react to insurance coverage information and then *provide the patient with information that the provider does not possess* regarding the network status of other providers under the patient's insurance and obtain various consents to further treatment. In practice, it is typically the insurer that will trigger the process of transferring a stabilized patient from an out-of-network to an in-network facility for financial reasons.

The draft bill's patient notice and consent burden on the providers is inconsistent with the practice of emergency medicine and will likely result in inadvertent EMTALA violations by putting physicians and hospitals in the impossible position of ascertaining and certifying:

- (i) The exact moment when the patient is "stabilized,"
- (ii) Such that the hospital can provide notice and secure consent for further treatment or transfer before undertaking any other OON medical services, and
- (iii) For the hospital to miraculously know and be able to advise the patient what the plan does and doesn't cover.

The draft bill places the burden for patient notification and consent in the wrong place; any notice and consent process should be placed on the insurer, should not be tied to “stabilization,” and must be effectuated in a manner that does not result in delayed treatment.

- It is the insurer who knows which facilities and providers are and are not in-network and what the patient’s potential cost may be. It is the insurer who is best positioned to ascertain options for transfer to an in-network facility with in-network physicians. Even if a patient is provided a list of in-network practitioners or hospitals with a referral, that is no guarantee that such providers are actually available and willing to *accept* the transfer.
- It is the insurer that would be financially motivated to transfer the patient to in-network providers. The patient’s cost-sharing amount is already protected at the in-network rate.
- Providers should be focused on providing care and treatment to their patients. It is not reasonable or feasible to place the burden on hospitals or doctors to magically possess and provide a list of in-network practitioners or hospitals. Neither patients nor physicians are in a position to call multiple hospitals to ascertain bed and service availability at the alternative hospitals solely for financial and non-clinical reasons. This is particularly concerning during flu season when many hospitals are bursting with patients and simply cannot accept transfers.
- As a matter of apportioning responsibility between the emergency services provider and the insurer for avoiding OON charges, it makes sense to incentivize the insurer to act in consultation with and on behalf of its insured policyholder when seeking to make transfers of stable inpatients solely for financial purposes.

Accordingly, we would suggest a different approach to defining the services that are covered and transparency provisions that incorporate an insurer notification and transfer component. A much simpler and more workable approach is to 1) define the appropriate endpoint for purposes of cost sharing, billing and payment as the point of discharge, coupled with 2) a simpler requirement that the provider timely notify the patient’s insurer that they are treating their insured on an OON basis arising out of an emergency incident.

This is consistent with real world notification practice and the obligation of the *insurer* to arrange on behalf of their insured for a receiving facility and medical officer to manage the transfer process in collaboration with the transferring hospital. The approach also addresses the situation of a non-emergency service that may be provided to a patient in an emergency department incident to an emergency department visit for an emergency condition (e.g. refilling an unrelated but needed and timely prescription for a patient prior to their being discharged from the emergency department). More specifically --

- The scope of covered emergency services should include those services provided to a patient presenting at an emergency department under the prudent layperson standard throughout the entire emergency medical encounter at the facility until the patient is discharged or transferred from the hospital, regardless of OON status and location (whether from the emergency department, observation unit, or inpatient unit).
- An insurer cannot deny coverage under the prudent layperson standard if, in the judgment of the treating clinician, the condition or conditions were emergent or potentially emergent.
- Upon ascertainment through reasonable inquiry that the patient is OON (with respect to the facility or the treating clinicians) within the confines of EMTALA, the patient’s insurer will be notified in a prompt manner.

- Once notified, if an insurer wishes to move a patient for the financial purpose of transferring a patient to an in-network facility with in-network clinicians, the insurer must ascertain whether there is a medically appropriate receiving facility **willing and able** to receive the patient, the insurer must bear the expense of the transport, the patient or legal representative must consent, and the treating clinician must certify that the patient is stable.

An approach of this nature would avoid the problems created by relying on EMTALA definitions, would more logically apportion the responsibilities of the various parties, would not interfere with medical decision making, would create a clearer point of demarcation connected to the patient's physically leaving the hospital facility rather than the fluid nature of "stabilization," and, most importantly, would most protect the patient.

Subsections (g) and (h)

The newly added subsection (g) of Section 2719A of the PHS would prohibit a provider from balance billing patients who receive emergency care, "regardless of the state in which the patient resides." ACEP supports protecting patients through a prohibition on balance billing for any amounts beyond the patient's in-network cost-sharing. But it is unclear if "the state in which the patient resides" is intended to also refer to the state in which the patient *received care*. What if the patient resides in one state, but receives emergency care in another state? Further, while we believe that it the Committee's intention to allow states to establish or maintain balance billing laws, it is unclear whether states with balance billing laws in effect that allow for higher patient cost-sharing for OON emergency care must now be subject to the requirements in the newly added subsection (g). The Committee should clarify this in the legislation.

The newly added subsection (h) seems to provide a general deference to any state law that determines "appropriate" compensation for the OON emergency services. Currently, only twelve states have any kind of laws in place to address surprise billing and three additional states have enacted laws that will soon go into effect. Leaving aside that some of these laws are problematic in and of themselves, as we are interpreting it, the Discussion Draft could allow insurers in 35 states to take advantage of the lack of *any* such law to significantly underpay OON emergency providers, and those providers would be unable to recoup any of the balance. This could lead to significant access problems when EDs in such states will begin to face difficulty in maintaining staffing levels necessary to providing high quality care.

In terms of the enforcement mechanism for the prohibition on balance billing, we urge the Committee to not penalize providers who may have *unknowingly* violated the new requirements. The civil monetary penalties (CMPs) applied to providers in the Discussion Draft who balance bill patients should *only* apply if there has been a pattern of behavior and/or willfulness, rather than a single unknowing instance. At minimum, the CMP safe harbor that is outlined in subsection (g)(2)(C) should be extended to apply if the facility or practitioner withdraws the violating bill within 30 days of *discovery* of the violation, not within 30 days of the violation itself.

Subtitle A – Option 1

Section 103 – In-network Guarantee

Under this option, in-network facilities would be required to guarantee to patients and insurers that every practitioner at that facility would also be considered in-network. **ACEP strongly opposes such a “network matching” requirement.**

Requiring all health care providers in a hospital to join the same insurance contracts as that hospital and charge the in-network rate would distort the contracting dynamic between emergency physician groups and insurers. It would completely remove the physician group’s ability to negotiate a contract, as the insurer would know the hospital is requiring the contract and would therefore offer only the lowest and most unfavorable terms.

Please consider the following example -- an emergency physician group practice for which 30 percent of their patients have private insurance, is negotiating with a health plan that accounts for 10 percent of their commercial volume and is in-network with their hospital(s). Upon the next renewal of their network agreement, if the practice doesn’t accept the plan’s rate offer, they would be forced to leave the hospital(s) and lose 100 percent of their volume due to a rate dispute affecting just 3 percent of their patients (30 percent commercial mix multiplied by 10 percent plan share).

Thus, in this scenario, one commercial contract negotiation has substantial asymmetric downside for the practice. The market for commercial health insurance is already highly concentrated, and therefore the relative bargaining power between commercial health insurers and physician groups is already heavily favors insurers in most markets. In a recent suit to stop anticompetitive mergers between four of five largest commercial health insurers several years ago, the Department of Justice stated¹,

“[C]ompetition is now at risk. Today, the industry is dominated by five large insurers commonly referred to as “the big five”... In a scramble to become even bigger, four of the big five now propose to merge ... These mergers would reshape the industry, eliminating two innovative competitors ... at a time when the industry is experimenting with new ways to lower healthcare costs. Other insurers lack the scope and scale to fill this competitive void. After the mergers, the big five would become the big three, each of which would have almost twice the revenue of the next largest insurer.”

As well, a recent study in Health Affairs noted that concentration of commercial health insurers is responsible for premium price increases, with premiums in areas with monopoly insurers 50 percent higher than in others.²

In addition, this “network matching” requirement in the Discussion Draft would be difficult to operationalize, especially from a timing perspective. Hospital contracts with insurers can be multi-year, so there would too often be scenarios where the hospital has dropped or changed a contract with a particular insurer, yet the physician group contract with that same insurer would not yet have expired, or vice-versa. As well, with consolidation in the health care sector continuing to grow, contracts on either end of the

¹ United States v. Aetna and Humana, July 21, 2016 <https://www.justice.gov/atr/case/us-and-plaintiffstates-v-aetna-inc-and-humana-inc>

² ACA Marketplace Premiums Grew More Rapidly in Areas with Monopoly Insurers Than in Areas with More Competition, August 2018, Health Affairs, p. 1243 (Marketplace Premiums).

hospital or physician side could be additionally disrupted and go further out of sync. Lastly, a single insurer often has numerous products that each reflect a range of network breadths. To try and align each of these products across each hospital and any physician groups involved will introduce even further additional administrative complexities.

The Discussion Draft offers as an alternative option that a practitioner may instead “elect” to bill the health plan through the facility, rather than sending separate bills to the patient or the health plan. **ACEP also strongly opposes this “bundling” option.** While the Center for Medicare & Medicaid Innovation (CMMI) has tested bundled payments for certain common conditions with predictable treatment protocols and outcomes such as hip and knee replacements under the Bundled Payment for Care Improvement (BPCI) Advanced Initiative, it would be extremely difficult for insurers to develop an accurate bundled payment for unscheduled and unpredictable emergency care episodes. Many people come to the ED with acute, undifferentiated conditions that may necessitate a broad range of services, tests, and procedures conducted by a range of providers. For example, two of the most common patient presentations are “chest pain” and “abdominal pain.” These initial symptoms have a large range of ultimate diagnoses and require a large variety of patient-specific lab tests, radiology exams, and other interventions. Patients could also wind up receiving care at other parts of a hospital or end up being transferred to another facility. Thus, it would be almost impossible in some cases to determine which services should be included in the episode.

Developing a system to sort this out would be extremely complex. It would represent another administrative cost to insurers, hospitals, and providers and could in fact lead to higher overall health care prices. How will facilities (and insurers, for that matter) keep track of which providers are in-network, and which are choosing to be billed under the bundled approach? Again, as contract timelines differ, this will be extremely administratively complex.

Furthermore, the idea that a bundling model would reduce costs to the system relies on the presumption that somehow hospitals will be more effective at negotiating a payment with physician staffing groups than the insurers have been, to date.

We must also note our very strong concerns with the newly added Section 2729A(d) of the PHS, which would only penalize the provider if the provider does not enter into a network contract with an insurer that is contracted with the facility in which the provider furnishes services. We firmly believe that any enforcement or penalties should also apply to insurers and that providers should be held harmless in cases where the insurer does negotiate with the provider in good faith.

Subtitle B – Option 2

Under this option, an Independent Dispute Resolution (IDR) process would be established that uses a third-party arbiter to make a final, binding decision when an OON billing dispute exists.

ACEP has supported using an arbitration mechanism as a back-stop to resolving OON billing disputes, and called for it as such in our Framework for Protecting Patients When Emergency Care is Out-of-Network released earlier this year³. Yet **we have strong concerns with the specific IDR approach**

³ ACEP’s framework can be found at: <http://www.acep.org/globalassets/new-pdfs/advocacy/acep-framework-for-addressing-oon-emergency-care.pdf>.

described in the Discussion Draft. As currently designed, especially for emergency physicians, **this is at best arbitration in name only**, and will essentially be no different than Option 3.

The Discussion Draft's IDR approach prevents providers from using arbitration if their bill is \$750 or less. For emergency physicians, this could represent a significant portion of their bills depending on where they practice, leaving them without any recourse if there is an OON dispute with an insurer. Instead, the draft legislation sets payment for bills under that threshold at the median contracted rate for services for that plan in that geographic area. We provide an in-depth explanation below in our comments on Option 3 on why this payment rate is problematic, and those apply here as well.

Additionally, even when a claim is over the \$750 threshold, **the IDR process as designed in the Discussion Draft is significantly flawed**, and we have strong concerns with it. The draft directs the arbiter to “consider relevant factors including the median contracted rate...offered by the group health plan or health insurance issuer in that geographic region.” We point you to our comments under Option 3 on why this factor in and of itself is problematic. But as part of arbitration, when it is the only statutorily referenced payment guideline for the arbitrator to base a decision on, we are left with an arbitration process that is largely just symbolic.

With that median contracted rate as the only payment guideline, it will be almost impossible for providers to prevail if their final offer is much more than the median contracted rate. Furthermore, because the arbitration in the Discussion Draft also includes a “loser pays” approach (which *can* be useful when packaged with a more effective arbitration approach that recognizes market forces), a provider could even face having to accept slightly below that median amount, since the cost of arbitration could be several hundred additional dollars, and not worth the risk of taking an underpayment through the process.

We instead strongly recommend the Committee adopt the proven and successful approach used in New York State for arbitration. This elegant approach, unlike the IDR process described in the Discussion Draft, will reduce the incidence of OON billing, incentivize greater network participation by providers and network adequacy by insurers, will *disincentivize* either party from going to arbitration to begin with, and adheres to free-market principles.

Under the established IDR process for emergency care, the arbitrator picks either the charge set by the provider or the original payment offered by the insurer, **without modification**. The party whose amount is not chosen **must pay for the cost of arbitration** (estimated by the State of NY to range from \$225 to \$325 per appeal), as well as any outstanding amounts as a result of the decision. Paired together, these two components of the IDR process in NY are the basis for its success—both the provider and the insurer are incentivized from the start to avoid arbitration (and the risk of paying for it if the other party initiates it and prevails), by being limited **ONLY** to their original charge and payment amounts, respectively. [This infographic demonstrates the process](#) and how in NY it provides a compelling backstop that strongly encourages all parties to be fair actors in setting charges and payments from the start.

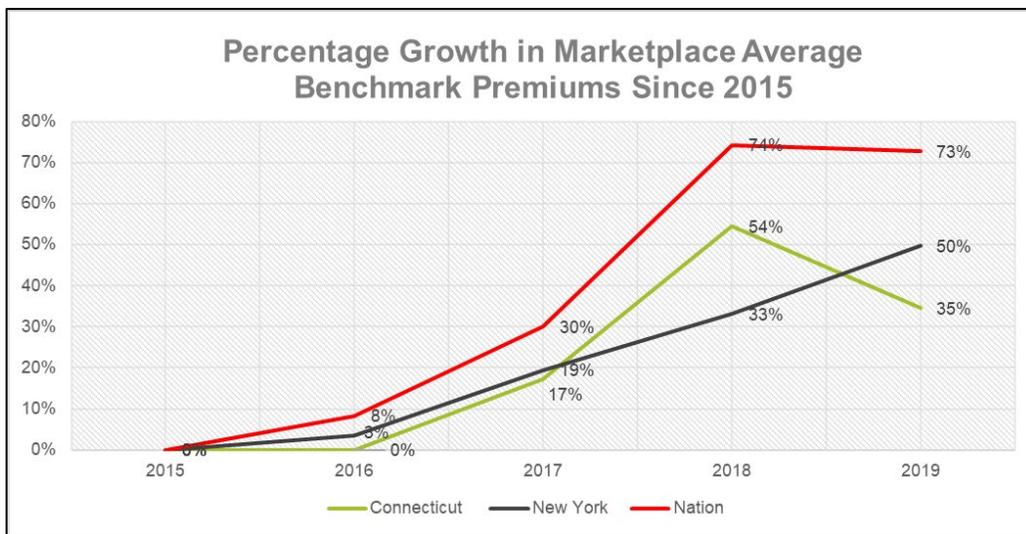
Since both parties have this powerful incentive to act fairly, most claims do not even need to go into the IDR process. As seen in the chart below, out of the millions of visits to the emergency department in 2018, only 849 emergency claims went to arbitration. As well, the decisions rendered on these were evenly split, further demonstrating that the system is working and is fair.

Emergency Services

Total received	849
Not eligible	162
Still in process	139
Decision rendered	548
Health Plan payment more reasonable	143
Provider charges more reasonable	176
Split decision	165
Settlement reached	64

The New York law has preserved access to emergency care and has not led to significant increases in insurance premiums. In fact, the Kaiser Family Foundation has shown that premiums in New York have grown more slowly than rates for the rest of the nation over the last five years⁴. Physician networks are stable and not declining. New York insurers reported to Georgetown University researchers⁵ that the law has incentivized insurers to have networks of physicians as “expansive as possible.” Further, a FAIR Health report shows that the “billed charge” payment rates have actually declined by 13 percent since enactment⁶.

Please see the graph below:



Source: Graph created using data from Kaiser Family Foundation (2015-2019): “Marketplace Average Benchmark Premiums.” Retrieved from <https://bit.ly/2tqy25F>.

Not all claims are included in the NY IDR process. Smaller claims for emergency services that are currently less than \$683.22 (annually adjusted for inflation) and do not exceed 120 percent of “usual and customary cost” (UCR) are automatically exempted. But in stark contrast to the Committee’s Discussion Draft, exempted claims must be paid at the charged rate if commercially reasonable and in line with UCR. UCR

⁴ Kaiser Family Foundation (2015-2019): “Marketplace Average Benchmark Premiums,” <https://www.kff.org/e4f94bd>

⁵ Corlette, S.; Hoppe, O. Georgetown University Health Policy Institute: Center on Health Insurance Reform, “New York’s 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study,” (May 2019). <https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0gpzdoew2zu9>.

⁶ The New York State Health Foundation, “Issue Brief: New York’s Efforts to Reform Surprise Medical Billing,” (February 2019), <https://nyshealthfoundation.org/wp-content/uploads/2019/02/new-yorks-efforts-to-reform-surprise-medical-billing.pdf>.

is defined as the 80th percentile of all charges for a health service rendered by a provider in the same or similar specialty and provided in the same geographic region as reported by an independent benchmarking database maintained by a nonprofit organization. New York identifies the FAIR Health charge database as an independent entity that can calculate UCR. Also of note, the NY law directs arbiters to consult FAIR Health database rates in making their decisions, but they do not constitute government rate-setting. Both insurers and physicians can submit additional information as outlined in the law to substantiate their payment position.

It is clear that the New York law has been a success, minimizing disruption, constraining costs, keeping premiums stable, and, most importantly, protecting consumers. **We therefore strongly urge the Committee to use this proven arbitration approach rather than the IDR process proposed in the Discussion Draft.**

At minimum, if the Committee proceeds with its own IDR process rather than using that of NY, we call for the following:

- Lower, or eliminate altogether, the IDR threshold of \$750, so that emergency physicians are not unduly prevented from seeking appropriate recourse for disputes through arbitration. If a threshold is kept, claims below it should not be paid at the median in-network rate but instead paid in full.
- Include a requirement (applicable to ERISA plans, at minimum) for timely automatic payment that requires insurers to have the provider receive payment within 30 days from receipt of the claim. Failure to provide the proper reimbursement amount or to comply with the timely pay requirement would trigger a civil monetary penalty (CMP) for the insurer/plan.
- Limit “final offers” to the original provider charge and insurer payment, which encourages all parties to be fair actors in setting charges and payments from the start.

Subtitle C – Option 3

ACEP strongly opposes the use of a benchmark for establishing OON payment amounts. Emergency physicians *want* to contract with insurers and accept low-discounted contract rates with private payors in exchange for certain benefits such as business certainty, reduced administrative burdens, and faster payments. Therefore, allowing insurers to access a discounted contract rate via benchmarked OON payments without providing the benefits of contracting in exchange will in turn discourage contracting altogether, and result in even narrower networks of physicians and less patient choice.

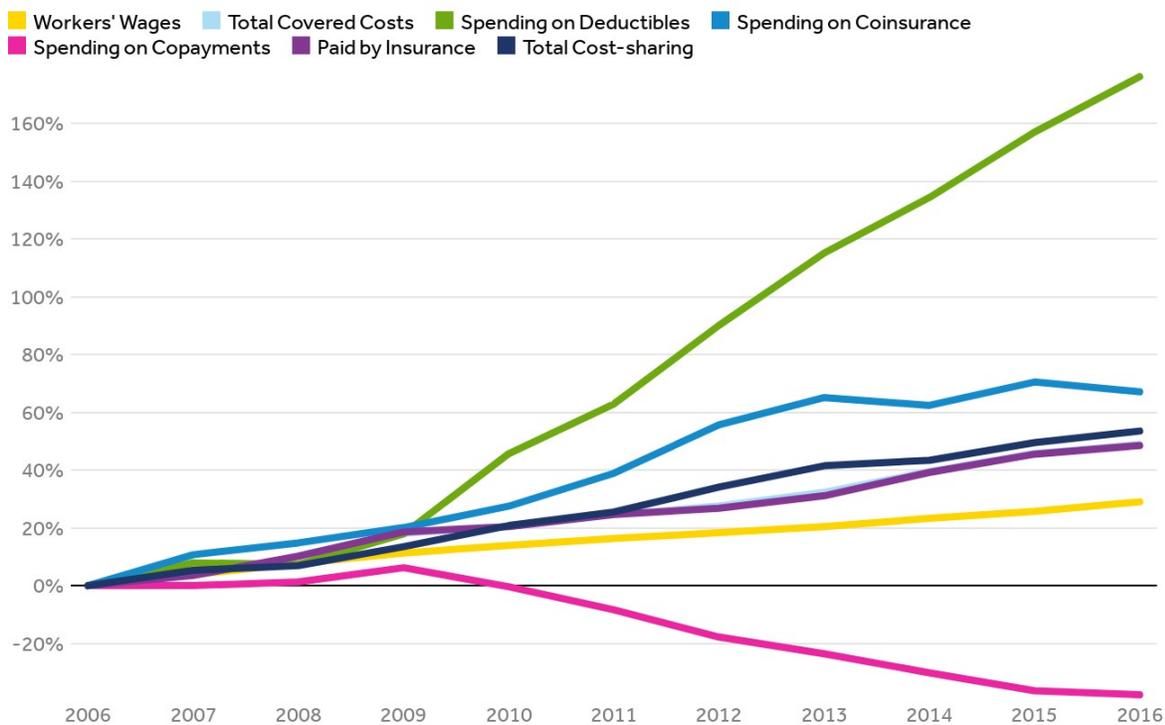
Discounted OON payments will severely harm emergency physicians’ ability to cover even just their practice costs and serve patients, given the additional challenges they face as safety net physicians who must absorb significant amounts of uncompensated and under-compensated care as a result of the EMTALA mandate.

Insurance design changes in recent years have raised deductibles to amounts far beyond what the average American can pay. As noted recently by the Kaiser Family Foundation (emphasis added),

“...from 2006 to 2016, average payments for deductibles and coinsurance among people with large employer coverage rose considerably faster than the total cost for covered benefits; however, the average payments for copayments fell during the same period. As can be seen in the chart below, over this time, **patient cost-sharing rose notably faster than insurer payments for care as health plans have become a little less generous in this regard.**”

This exponential skyrocketing of deductibles (top or green line in graph below) has resulted in a corresponding increase in the amount of bad debt that emergency physicians incur.

Cumulative increases in health costs, amounts paid by large employer insurance coverage, amounts paid for cost sharing and workers wages, 2006-2016



Source: Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2006-2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 2006-2016. • [Get the data](#) • [PNG](#)

Peterson-Kaiser
Health System Tracker

Accompanied by the further decline in Medicare reimbursements since then, as well as Medicaid expansion in many states that greatly increased the proportion of Medicaid patients, such losses continue to grow.

Emergency physicians are the only safety net for many in our country, including vulnerable uninsured, Medicare, Medicaid, and pediatric patients -- and therefore are already reimbursed at or below the cost of providing services for approximately three out of every four patients who present to the ED.

Should commercial insurance reimbursement rates be further scaled back via legislated rate-setting to median in-network rates, it will be very difficult for EDs to maintain the high fixed costs necessary to keeping the doors open 24 hours a day, seven days a week, and 365 days a year, especially for those in rural or urban underserved areas.

In the experience of a large ED physician group:

- Medicare patients, who generally make up 25 percent of the overall ED patient population – and are generally the sickest and most acute – reimburse, on average, \$145 per patient visit – or slightly below the \$150 average cost of care per ED patient visit to render professional emergency physician services (i.e., salary, benefits, professional liability insurance, continuing medical education, billing and overhead).
- Medicaid, representing about 30 percent of the overall population, reimburses roughly half of the emergency physicians’ cost of care, approximately, on average, \$75 per patient visits.
- The uninsured, who make up about 20 percent of the overall population, reimburse next to nothing.

A benchmarked payment based on commercial in-network rates (such as the legislation calls for) will also have a ripple effect on future contracts, since the OON payment rate becomes the new natural “high” in a geographic area, and future in-network contracts will always be lower. As this continues year-over-year, there will be a downward spiral with disastrous consequences for maintaining patient access to emergency care. High acuity and complexity sites, including EDs in rural areas (where it is harder already to recruit physicians) may especially be put at-risk with such a benchmarks cap on OON payments.

In California, for example, where OON payments are based on an average in-network contract rate somewhat similar to the Committee’s Discussion Draft, many insurers have decided they don’t need contracts because they can simply pay the lower rates established in the new law and refuse to contract. This has resulted in even further narrowing of networks and reduced access to care.

ACEP is also concerned with the Discussion Draft’s definition for *how* such median contracted rates are set. Of particular concern is the lack of transparency. Many insurers currently use an internally-derived “usual, customary, and reasonable (UCR)” amount to determine their OON payment rates, and experience has shown that even when criteria are set in state or federal law for OON emergency service payment, insurers frequently fail to adhere to these criteria, and regulators have failed to adequately enforce such adherence.

For example, as you may know, Congress enacted a provision in the Affordable Care Act forbidding insurers from imposing coverage limitations on OON emergency services that are more restrictive than any limitations imposed on in-network emergency services⁷. In 2010, the Obama Administration issued an interim final rule (IFR) to implement this provision. Since the statute did not ban balance billing, the IFR established a “reasonable payment” for OON emergency services. This payment amount was necessary because, otherwise, insurers might establish extremely low payment rates, thus subjecting patients to very high balance bills. The IFR established for this payment a “greatest of three” (GOT) methodology in which the insurer must pay the greatest of the following:

⁷ Section 2719A(b)(1)(C)(ii)(II) of the Public Health Service Act as added by Section 1001 of the Patient Protection and Affordable Care Act.

- the insurer’s in-network amount;
- the amount calculated by the same method the plan generally uses for OON services, such as the usual, customary, and reasonable (“UCR”) amount; or,
- the Medicare amount.

Unfortunately, the GOT policy did not have its intended effect of being a reasonable and objective payment standard, and we have repeatedly voiced concern with the second of the GOT standards since the IFR was promulgated in 2010.

The UCR amount is subject to insurer manipulation unless it is in some way objectively verifiable, and the term “usual, customary, and reasonable amount” is not an objective standard for calculating OON payments because it is not defined. Accordingly, we have recommended that the data supporting the calculation be subject to independent verification. In the end, because the underlying statute did not provide an appropriate amount of specificity surrounding payment, we found ourselves in a situation where the regulation that was necessary to fill in the missing details became a substantial threat to the financial viability of the emergency medicine profession and to patient access to qualified emergency physicians and ED on-call specialists. Not surprisingly, emergency physicians have seen payments for OON services drop significantly since the GOT regulation was issued in 2010.

In the Committee’s draft, median contracted rates are determined on a *per-plan* basis for providers in a certain geographic area. However, these rates could vary significantly between insurers with little or no transparency as to how such rates are determined. While we still oppose using the median contracted rate as a benchmark, if the committee maintains this standard, this rate should be determined using data from all plans in that particular geographic region – for example, a database maintained by an independent non-profit organization that is not affiliated, financially supported and/or otherwise supported by an issuer or by a supplier, such as FAIR Health. **Such a database should be transparent, statistically valid, and protected against conflict of interest.** This change should be reflected throughout the legislation wherever “median contracted rate” is concerned.

We strongly oppose use of any payment benchmark for setting OON payments in emergency care, but should one be used, it must therefore at minimum:

- be directly tied to an independent, transparent, and robust national database such as FAIR Health.
- data used to determine allowed amount benchmarks should include both in-network and out-of-network claims, from both ERISA and non-ERISA private, commercial plans alike, and include the copay and coinsurance. Given the variability that can exist in the payment amounts from a single insurer to a single provider across its own products (i.e. OON ERISA vs. small group vs. individual market), we are concerned the benchmark estimates will be skewed downward.
- be anchored to a specific year, with a medical cost of living inflation index added each year, to alleviate the “downward spiral” on future contracting described earlier in this section as well as insurer gaming of the benchmark through dropping some contracts.

Section 105 – Report

ACEP recommends that the report mandated under Section 105, in studying the effects of Sections 102, 103, and 104 on overall health care costs, specifically include health insurance premiums as part of this analysis.

An additional subsection (D) should also be included to evaluate how sections 102, 103, and 104 affect network adequacy. We strongly believe insurers must guarantee access to a sufficient number of contracted physicians (specialists, subspecialists, and primary care) and other health care providers in each geographic region who have the requisite training and expertise to provide that care, and in sufficient numbers, so patients may obtain timely access to all necessary medical care from in-network providers when possible.

TITLE III: IMPROVING TRANSPARENCY IN HEALTH CARE

Section 302 – Banning Anticompetitive Terms in Facility and Insurance Contracts that Limit Access to Higher Quality, Lower Cost Care

ACEP strongly agrees that patients should have access to affordable, high-quality health care. We ask that the Committee recognize the unique nature of emergency care in that patients cannot choose when and where they will have an emergency, and note our concern with the possibility that insurers could discourage patients (or “steer them away”) from seeking appropriate emergency care under the premise that such care is more expensive.

Section 303 – Designation of a Nongovernmental, Non-Profit Transparency Organization to Lower Americans’ Health Care Costs

ACEP generally supports the creation of a national claims database which could be used by authorized users for research, quality improvement, and cost-containment purposes. The Committee specifies certain criteria that the entity selected to establish and maintain the database must meet, including that it is a private, non-profit entity; that it conducts its business in an open and transparent manner; and that it is a certified entity under the Qualified Entity Program. **While ACEP agrees that these are all essential criteria, we strongly urge the Committee to add in an additional criterion: that the entity be independently owned and operated and not have any financial affiliation with a health plan.** We are concerned that without this criterion, data in the database could be biased and not representative of the true costs of care in a particular geographic region since a selected entity could lack the needed transparency and independence from insurers.

This section also would allow the Secretary of Labor in consultation with the Secretary of Health and Human Services to award grants to states to establish and maintain all-payer claims databases (APCDs) that would contribute data to the national claims database. We support the development of robust APCDs that mandate the collection of claims from all payers. Fifteen states have APCDs in place and numerous others are either considering or in the process of implementing APCDs. States can mandate submission of some data by state law, resulting in consistent, uniform data. In all, there are examples of strong state APCDs that collect claims data from all payers, such as Oregon, and others that are not as robust and only collect some data from those payers that voluntarily participate. Virginia’s APCD falls in the latter category; although it collects claims from almost every payer, it does not mandate collections, so insurers can pick

and choose what data to submit and thus leave room for data manipulation. [See Appendix B of a report](#) prepared by the University of Chicago’s NORC for a summary of APCD features by state as of May, 2017.

One technical issue with the current Discussion Draft relates to the appropriations language. The Committee should clarify that the \$100 million appropriation must be used solely for the actual grants to states. By stating that the appropriation would be used in “carrying out the grant program under this subsection,” the Secretary of Labor could use some of the funding for administrative purposes to establish the grants. Furthermore, the Discussion Draft should include a deadline by which the Secretary of Labor would be required to make the grants to states, or at least issue the funding opportunity announcement. This would ensure that grants are awarded to states in a timely manner.

Finally, this section also creates an advisory committee tasked with advising “the Secretary, the contracting entity, and Congress on the establishment, operations, and the use of the database established under this section.” This advisory committee would consist of eleven members “who have distinguished themselves in the fields of health services research, health economics, health informatics, or the governance of State all-payer claims databases, or who represent organizations likely to submit data to or use the database, including patients, employers, or employee organizations that sponsor group health plans, health care providers, health insurance issuers, and third-party administrators of group health plans.” Nine of these positions are explicitly defined and would include some of those aforementioned entities, though there is no guarantee the physician perspective would be represented on this committee. A physician could *potentially* be appointed to one of the remaining two additional positions that are not explicitly defined, but we believe it is necessary and reasonable to have a provider represented on this committee and their appointment clearly spelled out in the legislative language, as physicians will not only be contributors but also users of this national database.

Section 304 – Protecting Patients and Improving the Accuracy of Provider Directory Information

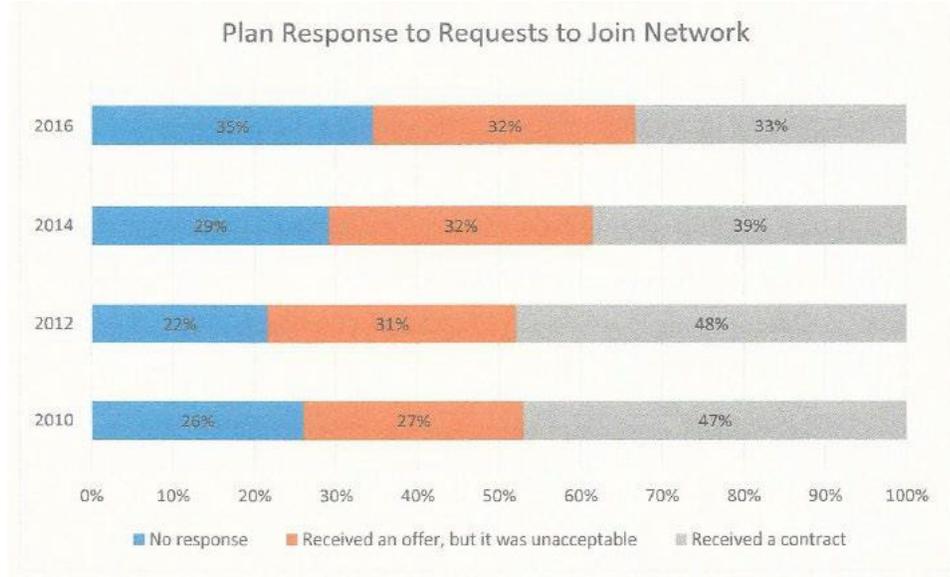
We appreciate the Committee’s inclusion of language that requires health plans to ensure in-network provider directories are accurate and updated regularly, and that enrollees have timely access to this information. With regard regular directory updates, the draft proposes that online directories be verified and updated at least once every 90 days. We suggest that directories be updated more regularly and suggest that at least one update every 30 days would be more useful to consumers.

Additionally, these patient protections should be further strengthened by including additional network adequacy standards that ensure an appropriate number of emergency physicians are in-network. In many parts of the country, insurers have near-monopolies (if not full monopolies) of market share; there are in fact numerous examples of a single plan controlling more than half of the market. Such market power allows insurers to offer take-it-or-leave-it contracts and narrow their physician networks, which just further exacerbates issues of OON care and the unexpected bills that can sometimes result. In fact, according to the Kaiser Family Foundation, the top three insurers in the large group market had a market share of at least 80 percent in 43 states in 2017⁸. Emergency physicians *want* to contract with insurers and provide in-network care. Physicians accept low- discounted contract rates with private payors because being in-network provides long-term certainty of a contract, allows for better projections of future business needs, and provides additional certainty of reimbursement directly from the insurer, rather than needing to pursue

⁸ Kaiser Family Foundation, “Market Share and Enrollment of Largest Three Insurers- Large Group Market,” available at <https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market>.

it from patients following their care. While all physicians enjoy benefits from being in-network, this last point is especially relevant to emergency physicians. Unlike many physicians of other specialties who practice in the community and can collect patient payment up-front before the patient is even allowed into a treatment room, EMTALA forbids emergency physicians from such practices.

While many states (and even federal law under the Affordable Care Act) require insurers to have adequate networks, these standards are not being enforced. For example, a 2016 survey of physicians in Texas by the Texas Medical Association found among physicians who approached a plan in an attempt to join its network, **35 percent received no response from the plan**—this was an increase of 6 percentage points from a survey in 2014, and a 13-point increase from 2012⁹.



As can be seen in the chart above, the percentage of surveyed physicians who received a contract correspondingly decreased over the same years, yet the percent who received an offer from the insurance plan but found it unacceptable (i.e. turned it down) remained stable. From this, we can draw the conclusion that the majority of physicians are continuing to make good faith efforts to be in-network but are being met with growing resistance from the insurance plans.

Similarly, in California there are numerous reports of insurers refusing to renew long-standing contracts (that paid more than the benchmarked OON rate of 125% of Medicare). Some insurers are terminating contracts unless physicians accept payment reductions as large as *forty percent*. Other payors are reportedly closing their networks to new physicians and most are reducing their physician networks overall in an effort to eliminate historical contracted rates from the industry benchmarking database to avoid having them serve as a basis for establishing the state contracted rates in the future. And overall, California premiums continue to rise.

The legislation should establish a federal patient emergency care access standard and ensure a corresponding enforcement mechanism. Otherwise, insurers will simply put profits over patients. This would require the Secretary of Labor, in consultation with the Secretary of Health and Human Services, to adopt quantitative standards that health plans or issuers of all commercial products (including ERISA)

⁹ Texas Medical Association, “Survey of Texas Physician 2016: Research Findings,” available at https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/2016_Physician_Survey_Findings.pdf

must meet in order to ensure access to a sufficient number of contracted physicians (specialists, subspecialists, and primary care) and other health care providers in each geographic region who have the requisite training and expertise to provide that care, and in sufficient numbers, so patients may obtain timely access to all necessary medical care from in-network providers when possible. The standard should include consideration of time, distance, and provider capacity within the relevant geographic area, and an effort to support such access through good faith, comprehensive efforts to contract with emergency treatment providers at reasonable/adequate rates and under timely payment terms.

Special consideration should be given to hospital-based physicians who provide emergency medical care under the federal EMTALA mandate as they cannot refuse treatment of any patient who presents themselves to the hospital emergency department. Without such consideration, insurers would have no incentive to contract with these providers.

As we note earlier with respect to enforcement mechanisms, civil monetary penalties for non-compliance should also apply for insurers that fail to comply with the requirements established in this section. As written, enforcement mechanisms in the Discussion Draft appear to apply only to health care providers, and insurers who do not provide timely and accurate provider directory updates face no repercussions.

Additionally, appropriate enforcement mechanisms should be extended to guarantee that insurers comply with the prudent layperson standard (already in existing law) for determining coverage for emergency care so that insured patients are not liable for unexpected costs simply because they were unable to accurately self-diagnose ahead of time whether their symptoms were in fact due to an emergency medical condition.

Section 305 – Timely Bills for Patients

ACEP agrees that patients should be provided with bills in a timely fashion. The Committee proposes requiring providers and facilities to send all bills to the patient within 30 days, and that providers and facilities give patients at least 30 business days to pay bills upon receipt. If a provider or facility does not send the bill within this time period, they are required to refund the patient for the full amount paid, with interest. Civil monetary penalties would apply to entities that submit more than 10 bills outside this period.

We are concerned that this time period (and subsequent enforcement) for sending bills to patients may disproportionately affect smaller practices and providers, especially those in rural and underserved communities, that simply may not have the resources to meet these requirements. We would suggest at least a 45-day window that would still ensure timely delivery of bills to patients and achieve the Committee's goal of eliminating egregiously-delayed bills.

Section 309 – Ensuring Enrollee Access to Cost-Sharing Information

Additional clarity is needed in this section to ensure that the 48-hour deadline to provide requested coverage information to the enrollee is related to “an elective health care service.” We believe it is the Committee's intent that this section apply only to scheduled health care services, but adding this clarification will ensure that this section is not misconstrued to suggest that emergency physicians providing EMTALA-related emergency services would somehow be required to furnish this cost-sharing information (which would constitute an EMTALA violation in and of itself).

TITLE IV: IMPROVING PUBLIC HEALTH

Section 401 – Improving Awareness of Disease Prevention

ACEP recognizes that vaccine-preventable infectious diseases have a significant effect on the health of adults and children. The emergency department is used frequently for health care by many inadequately vaccinated adults and children who are at risk for such diseases. Emergency departments serve as a primary interface between hospitals and the community at large and are likely to be called on to play a prominent role in the event of an emerging infectious or biological threat. To promote the health and well-being of individual patients and the population, ACEP appreciates your establishment of a national campaign to increase awareness of vaccines for the prevention and control of diseases, combat misinformation, and disseminate scientific and evidence-based vaccine-related information.

Section 402 – Grants to Address Vaccine-preventable Diseases

ACEP also supports your efforts to provide grants to address vaccine-preventable diseases. We suggest some of this funding be dedicated to providing annual influenza immunizations for health care providers (in the absence of an appropriate contraindication or exemption); delivering vaccinations in the emergency department for patients who do not have access to these services in other health care settings; and ensuring electronic vaccination records are accessible to emergency (and other) physicians.

For under-vaccinated patients, these grants should help emergency departments establish relationships with public health entities, urgent care and retail clinics, managed health care organizations, private physicians, and local pharmacies to ensure the rapid referral of these patients. Finally, grants should be available for emergency physicians when an outbreak or epidemic of vaccine-preventable diseases (including emerging infections and biological threats) is detected so we may assist health care facilities in partnering with public health agencies to develop and implement mass vaccination programs.

Section 404 – Expanding Capacity for Health Outcomes

ACEP supports the Committee's efforts to evaluate, develop, and expand the use of technology-enabled collaborative learning and capacity building models to increase access to health care services. With respect to increasing access to health care services, ACEP urges the committee to specifically recommend promoting the use of telehealth services.

Further, we believe that grants that the HHS Secretary would be required to reward should be specifically targeted at innovative telehealth initiatives. Different types of emergency care models have been tested, from "direct-to-consumer" models to models that involve a hub that connects emergency physicians to emergency departments in remote locations or allows emergency physicians to provide consultations for specific clinical conditions. In general, studies have shown that physicians and patients are extremely satisfied with the care being provided through these models, and costs have decreased due to avoided emergency department visits and inpatient admissions.

However, there are significant barriers to establishing new projects. Initial startup costs for telehealth programs can be high, even though they increase efficiencies and can result in lower costs once

implemented. These capital expenditures can include equipment, training, technical support, and additional personnel, and can be significant enough that they effectively limit uptake of telehealth services.

Section 405 – Public Health Data System Modernization

EDs are the nation's front line for all medical emergencies. Currently, there are no shortage of threats to our nation, whether they be natural or man-made. Emergency physicians are well trained to identify and manage infectious disease and disasters, and have practiced standard protocols to protect against blood-borne pathogens for at least 30 years.

An effective and time-sensitive early warning system needs to be implemented to facilitate the flow of critical public health safety data from the local jurisdiction, through regional and state agencies, for categorizing and sorting at the federal level. The current system can take too long to identify a developing health crisis and that time can be critical for treatment and containment. For these reasons, ACEP supports your efforts to award grants to state and local public health departments in an effort to expand and modernize public health surveillance and monitoring systems through improved data collection, simplified reporting, and enhanced interoperability.

However, advancements in collecting this information are inadequate without human interpretation and judgment in an evolving emergency situation. Emergency physicians play a vital role in this regard and we urge the HHS to direct some grant funding to ensure these enhanced technologies improve coordination of information not only vertically, but horizontally as well to connect emergency departments across the country, as well as all health-related disciplines.

Section 407 – Training for Health Care Providers

ACEP supports your efforts to establish a grant program to help reduce and prevent discrimination in all its forms. Emergency physicians are required by EMTALA to provide stabilizing treatment to all persons who present themselves to the emergency department. Based on our moral and legal obligations, we do not discriminate against any patient based on race, gender, national identity, or ability to pay.

We advocate tolerance and respect for the dignity of each individual and opposes all forms of discrimination against harassment of patients (as well as for our own emergency medicine staff) on the basis of an individual's race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, sexual orientation, or any other classification protected by local, state, or federal law. That being stated, we recognize that we can always do better to understand and empathize with our patients and their needs.

ACEP has already conducted implicit bias training for its Board of Directors and staff; planned similar training for participants of our Leadership and Advocacy Conference; developed an online course for emergency physicians; created a new Council Champion Award in Diversity and Inclusion; and established a Diversity, Inclusion, and Health Equity (DIHE) Section within ACEP.

Section 408 – Study on Training to Reduce and Prevent Discrimination

ACEP also supports the formation of an independent research organization to help supplement and direct the grant funding established in Sec. 407. Given the work we have already conducted in this area, we would encourage the research organization to look at how ACEP has already begun a similar process. Over the past few years, we have developed an unconscious bias online course, completed a systematic review of diversity and inclusion-related literature, conducted focus groups of our membership during our last annual meeting, and completed a diversity and inclusion toolkit for our members to use. It is important to develop evidence-based tools and training to educate health care professionals about diversity and inclusion issues, including implicit bias.

TITLE V: IMPROVING THE EXCHANGE OF HEALTH INFORMATION

Section 501 – Requirement to Provide Health Claims, Network, and Cost Information

Section 501 adds a new section, section 2715B, to Part A of title XXVII of the PHS. The newly added section 2715B(a) of the PHS would require health plans to make available for access, exchange, or use certain information (defined in the newly added Section 2715B(b) of the PHS) through application programming interfaces (APIs). ACEP supports the overarching principle that patients should own their healthcare data, and in general, believes that making this information available to consumers on open APIs is the right policy. While we cannot comment on the ability of health plans to implement the requirements included in the newly added Section 2715B of the PHS, we can offer specific comments from the provider’s perspective on time requirements for making the data available, privacy and security considerations, provider directories, and providers’ access to data stored on APIs.

Timing for making Data Available

The newly added section 2715B(b)(1)(A)(iii) requires the exchange of information (historical claims, provider encounter, and payment data) from any health plan that a patient was enrolled in from the previous five years. ACEP believes that patients who switch health care plans should have a way of accessing their data from their previous plan, and we agree that patients should own their data and that it should be transportable across payers and different health care settings. Payers already have information about the current and former enrollees, so we it is appropriate to require them to transmit that information upon request to a different plan within a five-year timeframe.

In terms of timing, the Discussion Draft requires health plans to make information available on an open API within three days after the information is received by the plans. **ACEP is extremely concerned that health plans will impose short, unrealistic turn-around times for providers to retrieve the information.** This could potentially increase administrative costs for providers, who would be required to update their systems to comply with the demands of the health plans. Furthermore, if providers cannot comply with payers’ new contractual requirements around submitting claims and encounter data, they may be forced out-of-network. As described further in the “Provider Information Directory” section below, narrow networks can make it difficult for patients to access the care they need. **Therefore, we strongly urge the Committee to add language to the legislation that would specifically prohibit payers from using these new requirements as an excuse to place additional contractual demands on clinicians.**

Quick deadlines could also lead to mistakes and inaccurate information being sent to the plans. These issues would be exacerbated in the emergency care setting. Due to the unpredictability of emergency care, sorting out claims for individual cases is a complex and timely process. **We therefore strongly recommend that the Committee relax the timeline for health plans to put encounter data and claims on open APIs.** While we understand the need to get information to consumers as quickly as possible so that they can make more informed decisions about their health care, what is even more important is that the information they are receiving is accurate.

Finally, we are concerned that some plans may attempt to pull information directly out of a provider's EHR to reduce burden and save time. While this may seem logical, a plan's full access to data could lead to selective, discriminatory reimbursement models and intrusion on physician medical decision-making power. ACEP strongly opposes any type of automatic, unfettered payer access to a physician's EHR, including through contractual means.

Provider Information Directory

ACEP supports the requirement under the newly added Section 2715B(b)(2) of the PHS that would require health plans to make provider directories available on open APIs. We are extremely concerned about the high prevalence of inaccurate provider directories in Medicare Advantage organizations (MAOs) and other public and private plans. A 2017 survey from the Center for Medicare & Medicaid Services (CMS) showed that over 45 percent of provider directory locations listed in MAO online directories were inaccurate. Recently, CMS concluded, after a three-year review of online MAO provider directories, that there has not been any improvement in the accuracy of these directories.¹⁰ Inaccurate provider directories can bring into question the adequacy and validity of a network. When individuals enroll in a plan, they have every right to expect that network adequacy criteria and standards for clinical and institutional providers will be monitored and enforced. Maintaining adequate networks is essential to ensuring that patients have access to the care they need.

As part of the new requirement added under Section 2715B(b)(2) of the PHS, provider directories would need to include estimated patient out-of-pocket costs for a designated set of common services or episodes of care that are defined partially in the legislation (i.e. the legislation lists out a minimum set of services) and that would be fully established by the HHS Secretary through rulemaking. **ACEP strongly urges the Committee to specifically exclude emergency services and episodes from this requirement.** With respect to emergency care, knowing what patients' total out-of-pocket costs will be before they are diagnosed and stabilized is nearly impossible until a proper course of medical care and progression is followed. A large proportion of emergency care involves the acute diagnosis, treatment, and stabilization of diffuse and undifferentiated clinical conditions. For example, two of the most common patient presentations are "chest pain" and "abdominal pain." These initial symptoms have a large range of ultimate diagnoses and require a large variety of patient-specific lab tests, radiology exams, and other interventions. This is very different from being able to figure out total costs for an urgent care patient with a small, clean, superficial laceration or a sore throat.

¹⁰ Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter, January 30, 2019, 164.
<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2020Part2.pdf>.

Like you, we strongly believe that a patient's concern should be focused on receiving the appropriate care, rather than choosing their care based on cost. In the ED, minutes and seconds matter and emergency physicians are often required to exercise their best clinical judgment quickly. Providing potentially inaccurate information about cost-sharing to patients upfront the chilling effect of dissuading patients from "coming to the emergency department." To do so could potentially cause the patient's health to deteriorate since it could delay the patient from receiving critical care.

Privacy and Security of Data

The newly added Section 2715B(c) of the PHS would require data on APIs to be made available by the health plan at no charge to health plan enrollees, third parties authorized by the enrollee (ie. third-party applications), facilities and practitioners who are under contract with the plan, and business associates of these facilities and practitioners. This new requirement would have huge implications on the ability for patients to protect their health information and ensure that their data are being used appropriately and according to their wishes. ACEP recognizes that we are entering into a whole new world in terms of data sharing and consumer access to their healthcare information and that it is even more essential now to protect that information after the initial encounter. As the ways in which information can be exchanged continue to grow, we believe that privacy and security laws need to be updated and extended to cover all possible types of data-sharing.

While we appreciate that the Committee affirms that all the privacy and security rules under the Health Insurance Portability and Accountability Act (HIPAA) and under State privacy laws must continue be followed, we believe that there is an enormous gap in existing laws that can potentially harm consumers. Some of the third-party applications that would now have access to sensitive health information are not be covered entities under HIPAA. They are instead regulated by the Federal Trade Commission (FTC), which has the authority to investigate and take action against unfair or deceptive trade practices.

As more and more third-party applications obtain data from open APIs, we need to think extremely carefully about how to ensure patient's information is protected and that these third-parties do not engage in any deceptive practices that could potentially jeopardize the privacy and security of the data. **First, ACEP strongly believes the information provided to third-party applications deserve at least the same protections as it receives under HIPAA even though it is not under control of a HIPAA covered entity.** Third-party applications can use data for a variety of purposes and we think it will be extremely difficult for patients to truly understand what aspects of their information are being shared and with whom. In fact, some studies suggest that current applications, like Facebook and Google, share information without the individual's knowledge or informed consent.¹¹ As the health IT applications ecosystem continues to evolve, patients need to be provided clear guidance and information about what they agree to when signing into an application and that their personal information could be at risk.

We are also concerned that providing patients with unfiltered data may be overwhelming and incomprehensible without the proper context and medical expertise to interpret the information. Payer data is often error-prone, and we believe that the burden may fall on the physician to identify and remedy the errors within the data patients receive through the third-party applications. **Therefore, we encourage**

¹¹ Huckvale K, Torous J, Larsen ME, Assessment of the Data Sharing and Privacy Practices of Smartphone Apps for Depression and Smoking Cessation, JAMA Netw Open. 2019;2(4):e192542. doi:10.1001/jamanetworkopen.2019.2542.

the Committee to work with the Senate Committee on Commerce, Science, and Transportation on additional language that would require the FTC to put out strong guidance or regulations that clearly articulate what are and are not acceptable uses of the data, using HIPAA privacy and security rules as a guiding benchmark.

We also encourage the Committee to go even further in the legislation to ensure that consumers are protected and that they truly understand how their data are being used. The Committee should require health plans to create an easy-to-understand questionnaire that they would require third-party applications to fill out in order to have access to the data on the open API. This questionnaire would include basic questions about how the third-party application plans to use the data. Consumers should have access to the answers on this questionnaire before using the third-party application. That way, even if the third-party application has a data use agreement that they require consumers to agree to, there will be another mandatory safeguard in place to ensure that consumers understand all the potential uses of their data once a third-party application retrieves all of it from the open API.

Providers' Access to Data Stored on APIs

ACEP supports the ability for providers to have access to the data on the APIs and thanks the Committee for including that requirement in the draft legislation. Having access to data on a patient can truly help emergency physicians make what could be life or death decisions. Furthermore, upon ED discharge, enabling all clinicians who are part of the patient's care team to have access to the information from that encounter will improve the whole team's ability to coordinate care for that patient. While provider access to information is extremely beneficial, we also do acknowledge that processes need to be established to ensure that patients' information is properly protected.

Section 503 – GAO Study on the Privacy and Security Risks of Electronic Transmission of Individually Identifiable Health Information to and from Entities not Covered by the Health Insurance Portability and Accountability Act.

ACEP supports the requirement for the Comptroller General of the United States to conduct a study which would, among other findings, “identify practices in the private sector, such as terms and conditions for use, relating to the privacy, disclosure, and secondary uses of individually identifiable health information transmitted electronically to or from entities, selected by an individual that are not subject to the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.” As stated previously, we are extremely concerned about how third-party applications that are not covered entities under HIPAA would use health information once they retrieve a patient's data from the API. While we believe that a General Accountability Office (GAO) study on this issue would be extremely important to conduct, we strongly urge the Committee to not wait until the GAO report comes out (one year after the enactment of the bill) to ensure that patients' data is protected. Instead, as suggested previously, the Committee should work with the Senate Committee on Commerce, Science, and Transportation on additional language to add to the legislation that would require the FTC to put out strong guidance or regulations that clearly articulate what are and are not acceptable uses of the data, using HIPAA privacy and security rules as a guiding benchmark.