March 4, 2025

Peter Nelson
Deputy Administrator & Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services

Dear Deputy Administrator Nelson:

On behalf of the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA), we write to you today regarding the No Surprises Act. As signed by President Trump in his first term, the law provides valuable patient protections for emergency patients and provides a proven, market-based independent dispute resolution (IDR) process that allows insurers and physicians to negotiate fairly and efficiently to resolve out of network billing disputes without putting the patient in the middle of the process. But recently a growing trend has emerged of health plans and insurers subverting and abusing this IDR process by submitting final offers of $0.00 to avoid paying emergency clinicians for their services.

As background, ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members, and the nearly 150 million Americans we treat on an annual basis. EDPMA is the nation's only professional trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes, together with billing, coding, and other professional support organizations that assist healthcare clinicians in our nation's emergency departments. EDPMA members see or support 60 percent of all annual emergency department visits in the country. Together, ACEP and EDPMA members provide a large majority of emergency care in our country, including rural and urban settings, in all fifty states and the District of Columbia.

Following an out-of-network patient visit and subsequent claim submission, the law requires plans and issuers to either 1) make an initial payment to the billing physician or group, or, 2) deny the submitted claim. The law's implementing regulations specify that this initial payment amount "should be an amount that the plan or issuer **reasonably intends to be payment in full** based on the relevant facts and circumstances and as required under the terms of the plan or coverage"[1] (emphasis added). If the physician disagrees with this initial payment, they can dispute it via the 30-day open negotiation period. Should there be no resolution during that period, either party has the option to initiate IDR.

An IDR offer of $0.00 by the insurer indicates that the plan believes the service provided by the physician had no monetary value; yet their initial payment of any amount higher than that (rather than an outright claim denial) signifies the plan had a good faith belief that the claim was indeed valid and reimbursable. In other words, a final offer of $0.00 contradicts entirely the insurer making an initial payment instead of denying the claim in the first step of the out-of-network billing process.

We do not believe the law contemplated such manipulation. Constructively—and retroactively—attributing $0.00 to an item or service is problematic for several reasons. First, by failing to deny the claim early in the process, insurers are blocking physicians from utilizing the normal and customary appeals process that follows a denial and does not increase costs for either party.

Second, the plan or issuer already made a payment on the claim, suggesting the plan or issuer believed at the time of payment that there is at least some value to the service rendered. Sending a final offer of $0.00 in IDR—which will

[1] Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,900-01 (July 13, 2021)

require a refund from the clinician to the plan or issuer should that offer be accepted by the IDR entity (IDRE)[2]—and results in the plan being unjustly enriched by not paying anything for a service rendered. Nearly all commercial insurance plans provide coverage for emergency services regardless of contract status. To require "coverage" but not "payment" for that coverage belies that some portion of the insurance premium includes the costs for emergency services.

Lastly, attributing $0.00 in the final stage of IDR circumvents the Prudent Layperson Standard[3]. The Departments clarified in the October 2021 interim final rules that the IDRE's role is *not* to make a determination of medical necessity. Yet a $0.00 offer is asking the IDRE to do just that, and by selecting a $0.00 offer, the IDRE is essentially determining that the emergency medical services rendered were not medically necessary. Again, this should have been an initial claim denial if medical necessity was in question.

To illustrate the growing use of this abusive insurer tactic, the 2023 CMS Public Use File data indicates that health plans made a final offer of $0.00 2,492 times that year. This may seem only a small proportion of the year's 162,422 IDR disputes for emergency services. But in 2024, data from *only two* EDPMA member groups showed over 13,300 zero-dollar offers made by insurers. In other words, these two groups alone in 2024 demonstrate a greater than 5-fold increase in the incidence of zero-dollar offers compared to *all groups nationwide* in 2023. We await the release of the 2024 Public Use File data, but anticipate that zero-dollar offers will be substantially more prevalent in this data set, pointing to a significant need for guidance.

2023 PUF Summary for Emergency Services	Q1	Q2	Q3	Q4	2023 Total	% Total
# of Disputes In Favor of Plan/Issuer	6,652	15,417	10,080	8,183	40,332	25%
# of Disputes In Favor of Provider/Facility/AA Provider	17,119	36,000	29,738	38,667	121,524	75%
# of Disputes with N/A value	558	3	2	3	566	0%
Total	**24,329**	**51,420**	**39,820**	**46,853**	**162,422**	**100%**
# of Disputes with $0 Plan Offers	398	620	716	758	2,492	

The No Surprises Act was expressly designed to reduce the need for IDR over time by bringing together providers and insurers on a level playing field to ultimately achieve greater numbers of reasonable in-network contracts. While it is clear from this table that providers are participating in the IDR process in good faith, given that they prevailed over insurers 75 percent of the time in 2023, the rapid rise in nonsensical zero-dollar offers from insurers demonstrates this good faith effort is increasingly one-sided.

Given this clear subversion by insurers of the law's process for resolving out-of-network billing disputes, **we request that CMS provide guidance instructing IDR entities to rule any offers of $0.00 as a de facto loss for the plan or issuer for the reasons stated herein**. Health insurance plans and issuers are harming patients, increasing administrative burdens, and driving up healthcare costs by illegally and improperly using the No Surprises Act's IDR process to avoid complying with the law's requirement to cover emergency medical services.

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[2] Per *IDR Guidance for Disputing Parties*, the "provider…will be liable to the plan when the offer selected by the certified IDR entity is less than the sum of the plan's initial payment and any cost sharing paid by the participant, beneficiary, or enrollee."

[3] The Prudent Lay Person Standard (PLP) is a federal law that protects patients by requiring insurance companies to cover emergency care based on a patient's symptoms, not their final diagnosis. PLP was intended to protect both the patients and the clinicians from "ex post facto" determinations that the patient's condition was not in fact a "true emergency." CMS has clearly stated that health plans cannot use the ex post facto final diagnosis as a basis to deny **either payment or coverage for emergency services, without violating the PLP**.

We appreciate CMS' attention to this critical issue, and would welcome an opportunity to discuss this in further detail with you where we could provide significant additional documentation of this growing issue. Please contact Erin Grossmann at egrossmann@acep.org or Christopher Krueger at ckrueger@kellencompany.com to arrange a date and time.

Sincerely,

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