

October 10, 2018

The Honorable Bill Cassidy, M.D.  
520 Hart Senate Office Building  
Washington, D.C. 20510

The Honorable Michael Bennet  
261 Russell Senate Office Building  
Washington, D.C. 20510

The Honorable Charles Grassley  
135 Hart Senate Office Building  
Washington, D.C. 20510

The Honorable Tom Carper  
513 Hart Senate Office Building  
Washington, D.C. 20510

The Honorable Todd Young  
400 Russell Senate Office Building  
Washington, D.C. 20510

The Honorable Claire McCaskill  
503 Hart Senate Office Building  
Washington, D.C. 20510

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Dean Wilkerson, JD, MBA, CAE

Dear Senators Cassidy, Bennet, Grassley, Carper, Young, and McCaskill:

On behalf of the American College of Emergency Physicians (ACEP) and our 38,000 members, thank you for the opportunity to share our comments and recommendations regarding your effort to better understand the costs of health care and improve price transparency and accountability for patients.

We appreciate the leadership demonstrated by the bipartisan price transparency workgroup in trying to address the health care bills facing so many Americans due to gaps in their insurance coverage of emergency care. The draft legislation released late last month offers a needed starting point for an open discussion of how best to address aspects of out-of-network care that are unique to the emergency department (ED).

We also appreciate the open process that your workgroup has taken to date, including the request for input in March that [ACEP responded to](#), as well as the cross-sector roundtable in July that we were invited to participate in. While we are grateful of today's additional opportunity to provide written feedback on the discussion draft in advance of a revised bill being introduced, we urge you to consider **allowing more time for input from stakeholders** before introducing a bill (which it has been suggested could be before the end of the month). A number of proposed provisions included in the draft represent a substantial shift from present-day processes and payment methodologies that are already complex, and therefore require significant data modeling to fully and accurately assess their potential impact should they be passed into law. In order to be able to provide your workgroup with the most comprehensive and constructive feedback (via these comments and in additional in-person discussion), we hope that you will consider extending the planned timeline for bill introduction. We look forward to meeting with your staff later this week as planned to discuss our comments in this letter in greater detail, and will be able to

provide an appropriate redline of the draft legislation following that discussion. Given the short timeline available for developing our written comments, we wanted to prioritize providing a substantive and helpful letter and then follow up with the corresponding redline by the end of the week.

Our specific comments on the legislative discussion draft follow, but in the aggregate, we urge you to keep in mind the particular issues that are unique to emergency medicine. In the emergency department, 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 two laws that are not entirely aligned – 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, and the Affordable Care Act (ACA), which includes emergency services as an essential benefit. In combination, the laws have had the effect of discouraging incentives for health plans to enter 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 able to access 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. They are further incentivized to keep their networks narrow since if a policyholder's emergency care happens to be out of network, the patient's deductible is likely significantly higher, 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 turn out to be 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.

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. We appreciate the opportunity to review and provide detailed comments regarding this draft legislation and stand ready to work with the members of this bipartisan workgroup 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](mailto: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 loop at the end.

Vidor E. Friedman, MD, FACEP  
ACEP President

**A. Section 2(a): Retitle Sec. 2719A(b)**

Currently, this provision of existing statute is titled “Coverage of Emergency Services.” In order to better reflect the intentions of the bipartisan Senate price transparency workgroup in developing the draft legislation, we recommend retitling it to “Protecting Patient Access to Emergency Care.”

**B. Section 2(a)(1): Resolution of Provider Billing**

The discussion draft would amend Sec. 2719A(b) of the Public Health Service Act (PHSA) to state that with respect to emergency services provided by an out-of-network provider, the provider may not balance bill the patient for amounts beyond the cost-sharing amount allowed under the subsection.

ACEP has strong concerns about such an across-the-board federal prohibition on balance billing without a corresponding across-the-board federal minimum benefit standard. A number of states have passed legislation that prohibits balance billing, but in doing so the prohibition has in almost all cases been accompanied by some kind of minimum benefit standard. Pairing the two mechanisms is critical to ensuring that providers are assured fair and sufficient reimbursement by a patient’s insurer, so that they may continue to provide access to high quality care for all emergency patients who seek it. As well, there are some states that have passed legislation that provides only a vague and undefined minimum benefit standard, such as New Jersey, which says only that insurers must reimburse out-of-network emergency providers at a “reasonable” rate. As currently written, the discussion draft could create scenarios where insurers take advantage of such ambiguity in a state’s law to significantly underpay out-of-network emergency providers, and those providers would be unable to recoup any of the balance due to an across-the-board federal prohibition. 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.

We therefore urge the workgroup to pair this balance billing prohibition with a corresponding minimum benefit standard that sets a defined federal floor for payments to out-of-network emergency providers. Should setting such a federal minimum prove challenging with regard to jurisdictional issues of state regulation of insurance coverage, we at minimum call on the balance billing prohibition to be moved to section (b)(4)(C)(ii), which will pair it with the minimum benefit standard the discussion draft establishes for out-of-network emergency care for ERISA plans and in those states with no applicable State law for determining the amount and manner of payment.

**C. (b)(4)(B): Retitle “Excess Amounts”**

The draft provision titled “Excess Amounts” sets requirements on what a health plan or issuer will pay to an out-of-network emergency provider beyond the patient’s cost-sharing responsibility. That amount is not an “excess,” since the provider’s services must be reimbursed. In an in-network scenario, a provider will receive payment from the insurer beyond the patients’ coinsurance or copay, and it is not considered an “excess.” It therefore is unclear why in the draft this would be described as such for out-of-network care.

We therefore request that this provision be retitled to “Minimum Benefit Standard,” which will not only provide additional clarity and ensure usage of a more common terminology, but prevent inadvertent further demonization of emergency physicians who seek only to be made whole for the services we provide to our patients, regardless of insurance status.

**D. (b)(4)(B)(i) and (ii): Clarify Applicability of Minimum Benefit Standard**

The draft language does not provide sufficient clarity as to how it would be ascertained that a State’s law does not provide for determining the amount or manner of the minimum benefit standard (MBS). Returning to the earlier example of New Jersey’s law that only specifies the payment be “reasonable,” would this meet the discussion draft’s test for the provider to be paid in such manner?

We therefore strongly urge that further specificity is built into this provision to better establish an applicability standard that defers to State law on manner and amount of payment only when such State law provides a clear, specific, and transparent methodology for doing so.

In most of the 20+ states that already have a statute, ambiguity in the language for defining an MBS means they do not provide comprehensive protections to both emergency physicians and the patients they serve. As a result, they lack sufficient protections to prevent a destabilization of the emergency medicine safety net in a plurality of these states, and cannot ensure consumers will have adequate emergency services available 24 hours a day, 7 days a week, 365 days of the year.

**E. (b)(4)(B)(ii): Minimum Benefit Standard Should Include Patient Cost-Sharing**

As currently drafted, the legislation will still result in patients often facing a confusion of bills from providers and Explanations of Benefits (EOBs) from their insurer following an out-of-network emergency medical encounter. Patients must be fully taken out of the middle in the billing process for these services.

In order to do so, we strongly recommend that the draft specify that regardless of assignment of benefit, plans or issuers shall directly pay a provider of emergency care services the full amount of the applicable MBS, including the patient’s cost-sharing amounts, for services provided during the course of the emergency medical encounter. The plans or issuers may then collect the appropriate co-pay from their insureds, ensuring that patients only need to correspond with a single entity in resolving their out-of-network encounter, rather than what is currently often a labyrinthine process of reconciling information received in communication with a hospital, multiple physician groups (depending on the complexity of the encounter), and the insurer.

**F. (C)(i): Eliminate or Retitle to “Median In-Network Amount”**

It is unclear why the “Greatest of Two” methodology proposed in the discussion draft includes the median in-network amount negotiated by the health plan or issuer in a particular geographical area as one of the prongs, since it is difficult to foresee this amount ever being higher than the second prong of the Usual, Customary, and Reasonable (UCR) rate. Physicians are to some degree free to negotiate contracts with individual payers, and in doing so will often exchange discounted payment for favorable contract terms such as faster and more straightforward processing of claims.

We therefore request the discussion draft set a single minimum benefit standard, calculated as described in the next section of our comments.

Should this not be possible, we urge this provision to be retitled to “Median In-Network Amount,” to more accurately reflect the methodology described therein. The median, or 50<sup>th</sup> percentile, is a more accurate and stable calculation than the average, which can be easily skewed by only a few outlier amounts in geographic areas that have limited collected claims for a particular service in whichever database is used to calculate the amount.

Lastly, the provision leaves some ambiguity on which negotiated in-network amounts are used in calculating the median. In order to ensure a fair and accurate calculation, the median cannot include negotiated rates for those providers participating in Medicare Advantage plans or Medicaid managed care organizations (MCOs).

**G. (C)(ii): The Usual, Customary, and Reasonable Rate Must Ensure a Fair Calculation**

While we appreciate that the discussion draft in this section attempts to define a specific and transparent methodology for calculating the UCR that a health plan or insurance issuer is required to pay to an out-of-network emergency provider, we have significant concerns with the methodology as proposed.

The provision states that the UCR shall be equal to 125 percent of the average allowed amount for all private health plans and insurance issuers for those services provided by a provider in the same geographical area, as determined using a database of statistically significant benchmarks that is transparent and maintained by a nonprofit organization unaffiliated with any plan or issuer. Our foremost concern is that such an approach could allow for potential “gaming” by insurers of the benchmarks in the database. Over time, insurers would be able to reduce their maximum allowed amounts, reducing the average for that service in the database, thereby lowering the corresponding UCR that is calculated from it.

As well, the few independent, transparent databases that exist have significantly less robust data on allowed amounts derived from claims for a specific geographical area when compared to that they have collected from claims on charges. Our understanding is that for one such database, FAIR Health, the allowed amount for a specific geographical area is actually an *imputed* allowed amount, derived by calculating the ratio of the regional averages of actual allowed amounts to the regional averages of actual billed charges and applying that ratio to the actual charges for that geographical area to determine allowed amount benchmarks. When there is an insufficient volume of imputed allowed amounts to provide a benchmark, the allowed benchmarks are derived based on data for a group of procedure codes to which a relative value and conversion factor methodology is applied.

We are therefore concerned that for a number of geographical areas that either see a lower volume of cases, or have fewer insurers voluntarily supplying claims data to a transparent, independent database, the allowed amount benchmark used for determining the UCR may lack accuracy.

Finally, the data used to determine allowed amount benchmarks include both in-network and out-of-network claims, from both ERISA and non-ERISA private, commercial plans alike, and includes 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. out-of-network ERISA vs. small group vs. individual market vs. in-network for each), and that the UCR prong of the discussion draft is meant to address only out-of-network payments, we are concerned the benchmark estimates will be skewed downward.

We therefore strongly urge the workgroup to use an approach that calculates the UCR based on a percentile of charges as determined by an independent, transparent benchmarking database—specifically, the 80<sup>th</sup> percentile. This is the approach that is being used successfully in several states to determine a MBS, including Connecticut, New York, and Alaska. Alaska has used the 80th percentile as the MBS since 2004, New York since 2015, and Connecticut since 2016, and in none of these locations has there been evidence that it caused premiums to increase. Competition, and community and hospital restraints, have successfully moderated any upward pressure on the MBS in these states. To alleviate any concerns that a UCR implemented as such at the federal level could result in charges increasing over time, we recommend

benchmarking the 80<sup>th</sup> percentile of charges to a specific year, with a medical cost of living inflation index added each year.

Another alternative approach that has been raised around recent discussions of the draft legislation is to use a blended formula combining a certain percentile of charges with a percentage (yet to be determined) of average allowed amounts for a particular geographic area. Such an approach could be seen as balancing the concerns and interests of providers with those of insurers. Were it to be considered, it would make sense to tie both the charge *and* the allowed amount portion of the formula to a specific year, with annual increases for medical inflation (similar to what is described above in our recommendation for charges).

Lastly, in discussions of a federal approach to alleviating large out-of-network bills for consumers, using a percentage of Medicare to calculate the UCR has on occasion also been raised as an alternative. We strongly oppose any approach that is based on Medicare rates, based on the following significant concerns:

- Medicare rates were never intended to reflect market rates, but rather are based on the amount of money that is available in the federal budget. Medicare therefore has not kept pace with inflation. In fact, Medicare physician payments have decreased 53 percent compared with the rate of inflation since the resource-based relative value scale system began in 1992. Future Medicare rates will suffer the same constraints.
- Medicare does not accurately reflect practice costs. In 2012, the American Medical Association noted there was a 20 percent gap between what Medicare pays and what it costs physicians to treat patients.
- Medicare rates were not designed for the general population, but were instead created for an age-specific group to ensure vulnerable, elderly patients can afford quality care. It was never intended to represent the fair market value of healthcare services or fully cover provider costs for the general population.
  - More importantly, because Medicare is meant only for a specific population, rates don't even exist for important aspects of patient care, including pediatrics and obstetrics.
- Medicare is changing. Under the Medicare Access and CHIP Reauthorization Act (MACRA), Medicare is being shifted towards a value-based payment approach. It is therefore unclear how operationally it could even be used as a basis for determining UCR in future years.
  - ACEP strongly supports offering providers opportunities to participate in value-based payment arrangements (and recently had its own physician-focused payment model recommended for full implementation by the PTAC), but it is very difficult to imagine how in the future Medicare value-based payment arrangements developed for an over-65 patient population could be used as a basis for determining UCR for an all-ages patient population.
  - If instead the current fee schedule were to be used and then provided annual increases for medical inflation, even that over time would become problematic. The work, practice expense, and malpractice RVUs that make up a payment rate for a particular service all undergo periodic adjustments to reflect changes and updates in technology, efficiency, and other variations that occur over time. Therefore over time such a basis for determining UCR will grow increasingly inaccurate.

Regardless of which methodology the legislation ultimately dictates for calculating the UCR that a health plan or insurance issuer is required to pay to an out-of-network emergency provider, we urge the workgroup to consider including the following additional protections for patients and providers:

- Plans/Issuers must provide claims data to the independent non-profit databank being utilized by the State (e.g., FAIR Health) or by the Secretary if the State does not utilize a database. Per the U.S. Supreme Court's ruling in *Gobeille v. Liberty Mutual Insurance Co.*, the Court held that states may not require ERISA plans to submit their data to a state's own all-payer claims database or designated independent database such as FAIR Health. But including such a requirement in federal statute will alleviate this barrier to ensuring databases used to calculate out-of-network payments are robust and accurate.
- The UCR should apply to the entire emergency medical encounter for the acute emergency medical condition, not just the EMTALA mandated screening exam and/ or stabilization of an emergency medical condition. For the reasons explained further in section H below, stabilization assessments generally occur in the context of whether a patient should or should not be transferred. Such assessments can take five minutes or five hours based on the medical condition of the patient. Stabilization may occur when the patient is still in the emergency department, observation unit or following an inpatient admission. The legislation should ensure that the reimbursement covers the entirety of the emergency encounter for the patient's emergency medical condition at the facility – from the patient's entrance into the emergency department through discharge from the ED or from an inpatient unit of the hospital. There should be no demarcation of payment for services before and after stabilization of the patient. The only demarcation line should be discharge from the facility.

The underlying statute in Section 2719 relies upon certain EMTALA definitions to ensure that coverage of emergency services includes at least those services required under EMTALA to provide for a medical screening evaluation and such further medical and examination and treatment to stabilize the patient. It is important to understand both what it means and does not mean "to stabilize" a patient under EMTALA. Under EMTALA, the term "to stabilize" means to provide such medical treatment of the emergency medical condition as may be necessary to assure, within reasonable probability, that no material deterioration of the condition is likely to occur. **Put simply, the term "to stabilize" means to treat the patient so that the medical condition does not deteriorate. It does not mean that the patient requires no more treatment once they are "stabilized." Treatment continues until the emergency condition has subsided sufficiently for the patient to be safely discharged from the emergency department or a hospital inpatient unit if admitted. Thus, to adequately protect patients, coverage must be provided for the entirety of their emergency medical encounter at the hospital facility, not just in the emergency department, and not just to the point of "stabilization."**

- A dispute resolution process is paired with a de minimis bill threshold, similar to that used in a number of states (including New York, Texas, Arizona, and New Jersey) a dispute resolution process for bills over a threshold for the amount charged. Such a provision encourages providers to charge below the threshold and saves time in processing claims. The threshold used in Arizona and New Jersey to reduce the frequency of mediation is \$1,000 per claim. If mediation is then required, the UCR methodology dictated in the legislation should be incorporated as the payment standard.

- Require that all bills must be reimbursed by the insurer to the provider, including copays and coinsurance, within 30 days from receipt of bill, with interest to the provider accruing from 30 days.

**H. (b)(4) and (b)(5): Defining Payment Rules and Notice Requirements Based on the Definition of “Emergency Services” and “Emergency Medical Condition” is unworkable.**

The draft legislation essentially relies on the EMTALA definitions of “emergency services” and “emergency medical condition” (as incorporated into Section 2719A of the Public Health Service Act by the Affordable Care Act) to define the parameters of the bill’s out-of-network payment requirements. We think that using those definitions creates some very practical problems vis-à-vis the Emergency Department operating environment and the meaningfulness of the patient notification requirements. We also think that the language needs to be revised to focus on an insurer notification element.

To begin with, it is important to note that EMTALA is a law designed to ensure that emergency treatment is provided irrespective of insurance status. EMTALA prohibits a hospital from delaying an appropriate medical screening examination or further medical examination and treatment in order to inquire about the individual’s method of payment or insurance status. As a result there is an inherent time lag between the provision of initial services and the ascertainment of whether the patient is insured and whether the emergency department or physician is in network.

Second, the definition of “emergency medical condition” relies on what is known as the “prudent layperson” standard. It is a definition that drives a determination as to whether the emergency department services for the perceived condition were necessary. This is essentially a medical coverage definition, and, in our membership’s experience, insurers apply their post-facto judgment to deny reimbursement for emergency department services where they determine that the layperson’s assessment of their condition as emergent was not prudent and, in effect, contradict the treating physician’s judgment.

As for the EMTALA definition of emergency services, it is used to define a provider treatment obligation in the context of when it is safe and appropriate to transfer a patient. It includes *at least* those services required under EMTALA to provide for a medical screening evaluation and such further services to “stabilize” the patient. Stabilization, in turn, means to provide such medical treatment of the emergency medical condition as may be necessary to assure, within reasonable probability, that no material deterioration of the condition is likely to occur upon transfer of the patient. (If a facility lacks the capacity to treat a patient, they can be transferred to a higher level of care irrespective of whether they are stabilized).

Relevant here then is the process by which a stabilized patient might be transferred from an out-of-network facility to an in-network facility for additional care. EMTALA requires the treating emergency physician to consult with the receiving facilities’ physician regarding the medical appropriateness of the transfer. This process involves medical judgment and case-by-case determinations arrived at by the relevant medical professionals. For example, some patients might be considered stable at the point at which they are moved from the Emergency Department to an in-patient bed whereas others might not.

The relevant point is that, as a practical matter, the point in time at which a patient is stabilized is not a clinically identified care endpoint, does not create a meaningful bright line to serve as a reimbursement cutoff point, and may actually be determined at a significantly later point in time than when stabilization was achieved. This makes it impractical as a basis for deciding when a patient must receive notification



and when a minimum benefit standard will no longer apply. During the course of treating a patient with an emergency medical condition, there is simply no “magic moment” when a physician is able to certify that the patient is stable such that the hospital personnel can simultaneously provide notification and secure a written acknowledgement of such notice “prior to providing additional services.” To require notification prior to providing any additional services post-stabilization puts patients at serious risk of delay in further treatment.

Finally, the draft bill creates a patient notification requirement when an insurer notification requirement would be more useful and relevant. The patient notification requirement is inconsistent with the practice of emergency medicine and will 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 secure simultaneous consent for further treatment or transfer before undertaking any other medical services and (iii) for the hospital to know and be able to advise the patient what the plan does and doesn’t cover. In practice, it is often the insurer that will trigger the process of transferring a stabilized patient from an out-of-network to an in-network facility. And as a matter of apportioning responsibility between the emergency services provider and the insurer for avoiding out-of-network charges, it makes sense to incentivize the insurer to act in consultation with and on behalf of its insured beneficiary.

**Accordingly, we would suggest a different approach to defining the services that are covered by the draft bill’s minimum benefit standard that incorporates an insurer notification and transfer component:**

- The scope of covered 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 from the hospital.
- 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 out-of-network (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 [and the patient will be notified at such point that, in the judgment of the treating clinician, she can meaningfully comprehend this information].
- Services provided to the beneficiary will be covered by the minimum benefit standard for the entire medical encounter, regardless of out-of-network status, up to the patient’s discharge from the hospital (whether from the emergency department, observation unit, or inpatient unit) or until such point that any transfer to an in-network facility occurs.
- If an insurer wishes to move a patient, not under EMTALA for the purpose of transferring to a receiving facility that can provide services beyond the scope of the transferring facility, but rather 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 such a transfer is medically appropriate as required under EMTALA.

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, and would create a clear point of demarcation connected to the patient's physically leaving the hospital facility.

**I. Sec. 3: HHS Study Should Be Expanded into Access to Quality and Affordable Emergency Care Commission**

While we greatly appreciate that the discussion draft includes a requirement that the Secretary of Health and Human Services conduct a comprehensive study on the impacts of the Act as well as recommend to Congress any potential changes to the law with respect to the issues described in paragraph (1) of the section, we strongly recommend broadening the scope and authority of this study and require the formation of an Access to Quality and Affordable Emergency Care Commission. Comprised of relevant providers, patients, insurance commissioners, insurers, and policy and financial experts, this Commission would be charged with developing and evaluating data and providing recommendations to Congress within four years of enactment on patient and provider protections that will ensure meaningful access to quality and affordable emergency care. The Commission should address key issues such as the adequacy of patient protections to ensure access to emergency care under the prudent layperson standard, how the statutory requirement for patient access for emergency care is effectuated, the degree to which uncompensated care is borne by clinicians under EMTALA, and whether creation of DSH-type supplemental funding for such uncompensated care should be approached.

**J. Additional Patient Protections**

Beyond the above recommendations for each section of the discussion draft, there are additional patient protections we strongly urge the workgroup to include in order to ensure patients can access high quality emergency care under their insurance coverage without fear of high, unexpected bills.

The first is to establish a federal patient emergency care access standard. This would require health plans or issuers of all commercial products (including ERISA) to demonstrate to their State Insurance Commissioner that their plans ensure patient access to emergency care for an emergency medical condition. 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.

The second is to increase transparency for policyholders for their emergency medical coverage. This would be comprised of two specific requirements:

- A) Plans or issuers must specify their insurance product on the patient's member ID card so that it is clear to both the patient and treating providers. 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 acute and scheduled care, having this information recorded in a patient's record can help the provider resolve billing issues and potential disputes on the patient's behalf, keeping the patient out of the middle.
- B) As well, plans or issuers must provide their enrollees with meaningful and simple explanations regarding coverage for emergency care that they are guaranteed under federal law. This includes informing them of the prudent layperson standard, which requires coverage for patients who seek emergency care for acute symptoms of sufficient severity (including severe pain) such that a prudent

layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or result in serious impairment of or dysfunction to any bodily organ or part. While this requirement is in federal law for all commercial plan types, over the past year insurers such as Anthem, United, and Blue Cross Blue Shield of Texas have all implemented policies that to varying degrees can retroactively deny coverage of emergency care for policyholders who seek it for symptoms that turn out to be non-emergent.