May 23, 2019

Congress is in recess next week for the Memorial Day holiday.

In this issue:

Capital Minute
This week, we dedicate the entire Capital Minute to the issue of surprise billing. Check it out here: https://www.youtube.com/watch?v=pcbdzxdjWn4 or click on the blue box below to view.

More Congressional Action This Week on Out-of-Network Billing

ACEP-Supported Surprise Medical Bill Legislation Announced in House
Earlier today, Congressman and Emergency Physician Raul Ruiz, along with Reps. Phil Roe (R-TN), Joe Morelle (D-NY), Van Taylor (R-TX), Dr. Ami Bera (D-CA), Dr. Larry Bucshon (R-IN), and Donna Shalala (D-FL) released a section-by-section outline of their bi-partisan legislative proposal, the "Protecting People from Surprise Medical Bills Act."

ACEP has been working with Dr. Ruiz's office on the bill's development over the last few months. The view the section-by-section, click here. To read ACEP's press release in support of the proposal, click here. Of all the draft legislation on surprise medical bills that have been released during the past two weeks, either by the committees of jurisdiction or individual Members of Congress, the only one to have

ACEP's full support is the Ruiz/Roe bill and we intend to promote this legislation to Members of Congress in both the House and Senate as the benchmark for this important legislative issue.

Overall, the bill follows the New York model for baseball-style arbitration very closely and then adds additional patient protections, several of which are directly from ACEP's Framework.

In summary, it:
•Applies to ERISA plans, as well as any state-regulated plans in a state that doesn't have a balance billing law that includes comparable patient protections
•Levels deductibles for emergency care to in-network amounts
•Requires insurers to put the deductible amount(s) on the patient's insurance card
•Has an automatic (initial) payment from the insurer to the OON provider of a "commercially reasonable" amount that must be paid within 30 days of receipt of claim
•Either party then can take it to arbitration if they don't feel that was an appropriate amount
•The arbitrator must pick between only the amount charged by the provider or the initial payment from the insurer
•Arbitration is time-limited to ensure neither party can drag it out Providers can batch claims to take to arbitration that are within 60 days of each other and for the same services
•Arbitrator guidelines have 80th percentile of charges based on a FAIR Health-like database (and then mostly NY-like other considerations)

Senate Committee Unveils Draft Surprise Medical Bill Legislation
The Senate Health, Education, Labor & Pensions (HELP) Committee also released a discussion draft of its bipartisan proposal to lower health care costs today, which includes a section on surprise billing. As expected, it does not provide a fair and reasonable balance between physicians and insurers regarding disputes over reimbursement above the patient's cost-sharing requirements. Essentially, the HELP proposal:
•Holds patients harmless from surprise medical bills. It only requires them to pay the in-network cost-sharing amount (including deductibles) for out-of-network emergency care and for care provided by ancillary out-of-network practitioners, and for out-of- network diagnostic services at in-network facilities.
•Facilities and practitioners are barred from sending patients "balance" bills for more than the in-network cost-sharing amount.
•If a patient is stabilized after entering a facility through the emergency room, the patient must be given advance notice of any out-of-network care, an estimate of the patient's costs for out-of-network care, and referrals for alternative options for in-network care. If a patient is not given adequate notice, the patient would be protected from surprise bills or out-of-network cost-sharing.
•Offers three options (of which the committee will chose one) on how to address surprise bills. Option one would require physicians to participate in the same insurance plans as the hospitals where they work (if you remain out-of-network, you would be required to bill through the hospital and if you can't reach an agreement with the insurer on reimbursement, they would pay the median in-network rate). Option two would create a threshold of $750. Any claims below that amount would automatically be paid at median in-network rates. Above the threshold could go to arbitration, but the arbitrator would required to "consider relevant factors including the median contracted rate." Option three would simply pay physicians and facilities at the median in-network rate.
•Requires air ambulance bills be broken out by air and medical charges.
•Requires facilities and providers to give patients a list of services rendered upon discharge. If patient doesn't receive bill within 30 business days, they would not have to pay it. Providers and facilities would have to give patients at least 30 business days to pay bills upon receipt.

The section-by-section and one-pagers for each title of the draft committee bill can be found here. ACEP will be developing a formal response to the HELP Committee over the next couple of weeks. The committee is expected to mark-up this legislation before the end of June with the goal of full Senate consideration in July.

House Committee Holds Hearing on Surprise Medical Bills

Additionally, the House Ways and Means Health Subcommittee held a hearing on surprise medical bills on Tuesday afternoon. Health Subcommittee Chairman Lloyd Doggett (D-TX), Ranking Member Devin Nunes (R-CA), and Subcommittee Members from both parties emphasized they are seeking bi-partisan solutions to hold patients harmless from surprise medical bills and resolve payment conflicts between insurers and providers. Throughout the hearing, Members and witnesses agreed that patients should be protected from balance billing when they are unknowingly treated by out-of-network providers, and generally supported federal legislation as necessary to protect patients in ERISA plans that are not subject to state health insurance regulation.

Witnesses at the hearing included two Members of Congress, Reps. Katie Porter (D-CA) and Cathy McMorris Rogers (R-WA), who shared their own stories about receiving a surprise bill, as well as representatives from the AMA, AHA, AHIP, and the ERISA Industry Committee (ERIC).

Emergency Preparedness Bill Approved in Senate

On May 16th, the ACEP-supported bill to reauthorize certain public health security and all-hazards preparedness and response programs authorized under the Public Health Service Act and Federal Food, Drug, and Cosmetic Act (S. 1379) passed the Senate by voice vote.

This bill, which was referred to the Senate Health, Education, Labor, and Pensions (HELP) Committee, includes the Pandemic and All-Hazards Preparedness Act (PAHPA) provisions included in H.R. 269, which was passed by the House of Representatives on January 8, that also included other FDA-related provisions that are not part of S. 1379. We expect the House to take action on the Senate bill the first week of June.

Mental Health Action Alert: Ask your Lawmaker to Cosponsor S. 1334/ H.R. 2519

Last week, you and other members of the 911 Legislative Network received an action alert email asking you to contact your lawmakers to cosponsor S. 1334/ H.R. 2519, the Improving Mental Health Access from the Emergency Department Act. This new legislation was drafted by ACEP and introduced on May 3 and would provide additional resources for patients with acute mental health needs who seek care in the ED due to a critical shortage of inpatient and outpatient resources. It was introduced in the House of Representatives by Rep. Raul Ruiz (D-CA), who is also a board-certified emergency physician, and in the Senate by Sens. Shelley Moore Capito (R-WV) and Maggie Hassan (D-NH).

While on Capitol Hill during ACEP's Leadership and Advocacy Conference, hundreds of emergency physicians educated legislators about the challenges they face providing care for psychiatric patients in the emergency department and asked for their co-sponsorship of this important legislation. At the time, we did not have bill numbers assigned to the legislation. Now that we do, **we want all members of the 911 Network to reach out to your legislators to ask for their support and co-sponsorship to keep the momentum going on this issue.**

Please click here to Ask your US Legislators to Co-Sponsor the Improving Mental Health Access from the Emergency Department (S. 1334/ H.R. 2519) today!

CMS Releases the ET3 Model Request for Applications

In February 2019, CMS announced a voluntary payment model called the Emergency Triage, Treat, and Transport (ET3) Model. The model will allow Medicare to pay ambulance providers for taking beneficiaries to alternative destinations beyond the ED (such as urgent care centers and primary care clinics). It also would reimburse for treatments provided in place by a qualified health care practitioner (physician, NP, or PA) either in-person on the scene of the 911 emergency response or via telehealth.

At the time of the release, CMS did not provide many operational or payment details, stating that more information would be included in the request for applications (RFA). On Wednesday, CMS released the RFA, as well as a long list of frequently asked questions (FAQs).

Although CMS released the RFA, the agency is not accepting applications yet. CMS wanted to give stakeholders some time to review the RFA before initiating the application process.

Please feel free to reach out to Jeffrey Davis, ACEP's Director of Regulatory Affairs, at jdavis@acep.org for more information about this model.

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