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Donald M. Berwick, MD, MPP, FRCP
Administrator, Centers for Medicare & Medicaid Services
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-1850

Attention: OCIO-9994-IFC

Re: PPACA Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections Interim Final Rule

Dear Dr. Berwick:

The California Chapter of the American College of Emergency Physicians would like to recommend amendments to the Patient Protections Interim Final Rule related to emergency care services and claims.

One of the stated objectives of these regulations to ensure that “any cost sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-network”. CAL/ACEP believes that this first objective has been met with the proposed language in these final rules.

Another objective is stated as follows: “To avoid the circumvention of the protections of PHS Act section 2719A, it is necessary that a reasonable amount be paid before a patient becomes responsible for a balance billing amount. Thus, these interim final regulations require that a reasonable amount be paid for services by some objective standard.” CAL/ACEP believes that this second objective has not been met.

The proposal in these final rules which allows plans to pay the greater of three objective standards (the amount that the plan usually pays to in-network providers, the plan's usual and customary payment to out of network providers, or the Medicare rate) fails to ensure that a reasonable amount will be paid before the patient becomes responsible for paying the unpaid balance. In addition, CAL/ACEP believes it will be difficult if not impossible for enrollees, providers, and perhaps even regulators, to determine if the plan has paid any particular claim in compliance with these regulations; and thus these proposed regulations fail the test of transparency that is another objective of health reform.

First, the payments that a plan pays to contracted in-network providers are typically closely held by the plan by virtue of confidentiality provisions in contracts between the plan and providers. Plans would be understandably reluctant to publish these payment rates, or even reveal them through EOBs in individual claims payments. In addition, the amount in dollars that a plan pays to contracted providers does not reflect the true economic value of the payment for these services. The full value of a discounted, contracted service is equal to the contracted payment amount PLUS the economic value of the considerations given by the plan to the provider in exchange for the discount, such as volume referrals or accelerated payment. Thus, a payment standard based on contracted payment rates under-represents the full and actual value of the reimbursement to the contracted provider, and thus is by definition 'unreasonably low' when applied to non-contracted providers who do not receive these other economic considerations.

Second, allowing a plan to pay the rate that the plan unilaterally decides to pay to non-contracted providers means that the plan may be allowed to pay substantially below the provider's full charge, even if that charge is quite reasonable. This standard would allow plans to make unreasonably low payments to out-of-network providers, especially if the plan is able to negotiate very deep discounts from contracted providers through unfair local market leverage. As a consequence, the enrollee would be responsible for a very substantial portion of the provider's charge.

Third, Medicare rates are so far below the other two standards that Medicare rates would rarely apply, and inclusion of this standard just makes the determination of the appropriate payment that much more complicated and obscure.

In order to ensure transparency, make it easy for enrollees and providers to know how much to expect the plan to pay for any one particular service from a non-contracted emergency care provider, and ensure compliance with these regulations; a single published payment standard for these claims should apply. If you assume that the enrollee in an emergency care situation deserves to have a benefit, and the provider a payment, which reflects the reasonable market value of the service provided; this payment standard should reflect this reasonable value. Like other health care providers, most emergency care providers set their fees based on market considerations: what other providers charge in their area for similar services, the CPT-RVU standard that has been widely adopted in the market, and the necessity to avoid pricing themselves out of the market. Thus, most emergency care providers' charges are likely to be not only usual and customary, but also a reflection of the reasonable market value of these services. In the U.S. economy, that is how reasonable charges for services are defined.

Establishing a payment standard for out-of-network emergency care provider payment rates that is based on the lesser of the provider's charge or the 75th percentile of usual and customary charges ensures not only that the payment will be reasonable, but also that it will be equal to or close to most providers' charges, thus limiting any unpaid balance that the patient may be

responsible for. In addition, a validated database of usual and customary charges can be published on the Internet without undermining confidential contracting rates, and can be easily accessed by enrollees, providers and regulators wishing to ensure that the plan is compliant with these regulations when making payment for these services.

For these reasons, we would like to propose the following amendments to the interim final rules on page 37227:

(C) Applicable cost sharing.

(3) Cost-sharing requirements—(i)

Copayments and coinsurance. Any costsharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-network. However, a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under this paragraph (b)(3)(i). A group health plan or health insurance issuer complies with the requirements of this paragraph (b)(3) if it provides benefits with respect to an emergency service in an amount equal to ~~the greatest of the three amounts specified in paragraphs (b)(3)(i)(A), (b)(3)(i)(B), and (b)(3)(i)(C) of this section (which are adjusted for in-network cost-sharing requirements).~~

~~(A) The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. If there is more than one amount negotiated with in-network providers for the emergency service, the amount described under this paragraph (b)(3)(i)(A) is the median of these amounts, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. In determining the median described in the preceding sentence, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the amount under this paragraph (b)(3)(i)(A) is disregarded.~~

~~(B) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable payment amount), excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. The amount in this paragraph (b)(3)(i)(B) is determined without reduction for out-of-network cost sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services.~~

~~Thus, for example, if a plan generally pays 70 percent of the usual, customary, and reasonable amount for out-of-network services, the amount in this paragraph (b)(3)(i)(B) for an emergency service is the total (that is, 100 percent) of the plan's usual, customary, and reasonable payment amount for the service, not reduced by the 30 percent coinsurance that would generally apply to out-of-network services (but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network).~~

~~(C) The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary the amount that is the lesser of the provider's charge or the 75th percentile of usual and customary charges, based on a database of usual and customary non-participating charges of providers in the same medical specialty and located in the same geographic area as the provider, reduced by the in-network copayment or coinsurance amount that the individual would be responsible for if the emergency~~

service had been provided in-network. This database shall meet requirements which ensure the accuracy of the non-participating, commercially insured claims data used to calculate these usual and customary charges, including the transparency, currency, statistical validity and protections against conflict of interest mandated by the New York Attorney General, and which is certified by an independent auditor. The FAIR Health database of usual and customary charges, once it is published, shall be the selected database to be utilized.

CAL/ACEP believes this amendment will ensure that the interim final rules avoid the circumvention of the protections of PHS Act section 2719A, by requiring that a reasonable amount be paid before a patient becomes responsible for a balance billing amount, and by defining this 'reasonable amount' in a way that is objective, transparent, enforceable, and results in payments that are based on the reasonable and customary market value of non-contracted emergency care services to commercially insured enrollees.

Sincerely,

Handwritten signature of Andrea Brault MD in black ink.

Andrea Brault, MD, FACEP
President, CAL/ACEP

Handwritten signature of Myles Riner MD in black ink.

Myles Riner, MD, FACEP
Past President, CAL/ACEP