

August 25, 2010

By Electronic Submission

Jay Angoff
Director
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: *OClIO-9994-IFC; Interim Final Rule - Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections*

Dear Director Angoff,

On behalf of the Emergency Department Practice Management Association (EDPMA) and its 83 affiliated members, we appreciate the opportunity to provide comments on the Interim Final Regulations for the Patient Protection and Affordable Care Act (PPACA): Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections (the "Interim Final Regulations"), as published on June 28, 2010 (75 Fed. Reg. 37188).

The EDPMA is one of the nation's largest trade associations that support the delivery of emergency medical care to Americans. EDPMA's membership includes emergency department physician groups of all sizes, as well as organizations that support these groups. Our membership impacts over 50% of the 119 million patients seen in U.S. emergency departments each year, representing one of the most important safety nets in America's health care system.

Patient Protections – Emergency Services

EDPMA strongly supports the patient protections enacted in the PPACA and their application to group and individual coverage. The PPACA seeks to protect current insurance coverage as well as to expand coverage. The patient protections included in the PPACA will help ensure, along with careful monitoring and enforcement by the relevant Agencies, that the insurance coverage provided to all individuals is meaningful. EDPMA was a strong supporter of these provisions during the Congressional consideration. EDPMA looks forward to working with the Office of Consumer Information and Insurance Oversight to make sure that the law and the Interim Final Regulations do, in fact, protect the patients our members see every day in the nation's emergency departments.

EDPMA believes that the Departments have taken strong first steps to translate the patient protections found in the PPACA into the Interim Final Regulations. Of particular importance to EDPMA are the PPACA requirements to cover emergency services: 1) without the need for any prior authorization determination, 2) without more restrictive benefits, co-payments, and administrative requirements for services outside of an insurer's provider network, 3) in all cases

where a prudent layperson determines his or her symptoms may indicate the presence of an emergency condition.

We applaud your approach in implementing these protections. We appreciate that the regulations recognize that the statutory intent would be thwarted if the plan or issuer paid an “unreasonably low amount to the provider.” Although the statute clearly permits balance billing, we agree that balance billing is a generally a provider’s reluctant response to an insurer’s attempt to issue unreasonably low payment amounts to non-contracted providers. As a result, insurers and plans consequently subject their members and beneficiaries to balance billing for services which otherwise remain poorly compensated. Additionally, it would defeat the purpose of the protections if such low payments were made. We also appreciate the difficulty in determining what would be appropriate payment levels. Due to this difficulty, we are hopeful that the Agencies will closely monitor practices in this area and adjust the standards as appropriate.

In the interim, we suggest below several areas for modifications to the Interim Final Regulations. We would be happy to meet with the Department to discuss any of these areas at greater length.

Cost – sharing requirements

The Interim Final Regulations establish an approach to determine when a plan or issuer would be regarded as being in compliance with the cost-sharing restrictions of the statute. In short, the approach states that if the plan or issuer provides benefits equal to the greatest of: 1) median in-network rate, 2) the rate generally used to calculate out-of-network payments; or, 3) the Medicare rate; it will be regarded as not violating the prohibition on differential limits for emergency services received out of network as opposed to in-network. We encourage the Agencies to work with hospital and physician providers of emergency services to determine how this approach works in practice. We are concerned that insurers may continue to make inappropriately low payments to emergency service physicians and thereby potentially dilute the patient protections set forth by Congress. EDPMA would be happy to provide feedback and expertise from our members as this regulation comes into effect. We also have some initial suggestions and requests for clarification:

First, we believe that the language stating, “a plan or issuer satisfies the copayment and coinsurance limitations in the statute if it provides benefits for out-of-network emergency services in an amount *equal to the greatest of* three possible amounts,” should be modified to read, “*at least the greatest of* three possible amounts.” Requiring plans and issuers to consider paying exactly the amount equal to the greatest will be administratively difficult and could actually encourage plans and issuers to lower payments from current levels.

We would like clarification regarding how emergency services providers, and ultimately the Agencies will determine each plan or issuer’s median in-network rate. Plans frequently have many in-network rates applicable across different geographic areas and/or types of providers. Also, much of the information necessary to determine median in-network rate is typically proprietary, and thus, we would like to see a mechanism for reporting and enforcement spelled out in the regulations.

In reference to the “generally used out-of-network rate” payment option, we would support use of a usual and customary rate approach, or other mechanism that does not rely on a plan or issuer’s

sole determination of “reasonable.” The terms “usual and customary” reference a fact based evaluation, while the term “reasonable” could be subject to various interpretations. Further, “usual and customary” determinations must be transparent and accountable to state and federal authorities for enforcement. In the past, insurers have consistently manipulated data to justify lower payments for out of network services. Some objective standard, (possibly, the FAIR health data currently being developed after a settlement between Ingenix, Inc. and the state of New York,) is necessary to establish fair out-of-network charges.

A minor clarification may be in order with respect to the Medicare rate as one of the three payment rates. We believe that the Agencies should clarify that the Medicare payment rate would be adjusted to take into account the location of the hospital where the physician provided the emergency services.

Evaluating the three differing methodologies for payment highlights the complexity of this area. We realize that any regulations in this area will present a need for interpretation as well as enforcement challenges, but we hope that the Agency will work with relevant stakeholders to fine-tune a reasonable approach which balances the need for certainty with the need for full patient protection.

We would note that the Examples provided in the Interim Final Regulations may raise additional questions. For instance, Example 1 outlines these facts:

A group health plan imposes a 25% coinsurance responsibility on individuals who are furnished emergency services, whether provided in network or out of network. If a covered individual notifies the plan within two business days after the day an individual receives treatment in an emergency department, the plan reduces the coinsurance rate to 15%.

The conclusion finds:

The requirement to notify the plan in order to receive a reduction in the coinsurance rate does not violate the requirement that the plan cover emergency services without the need for any prior authorization determination. This is the result even if the plan required that it be notified before or at the time of receiving services at the emergency department in order to receive a reduction in the coinsurance rate.

Though the policy described in this example would not violate the prior authorization requirement; it arguably imposes a cost-sharing requirement on the enrollee that would exceed that of an enrollee going to an in-network provider. We believe this approach would violate the statute. Therefore, this example should not be included as highlighting a compliant practice. Also, it is not clear to us, if a dispute such as this did arise, who would monitor and enforce the regulations. We seek clarification on insurer reporting requirements, monitoring functions, agency jurisdiction, and the appropriate avenue for provider complaint. We hope to work with your office in developing the proper approach.

Finally, EDPMA suggests that the Interim Final Regulations add a provision requiring insurers to honor “assignment of benefit” agreements between patients and providers. Some insurers refuse to pay providers directly for out-of-network costs and will send payments to the patient. Patients often do not realize that these payments were meant for physicians, leading to confusion and

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added administrative expense to collect. By allowing patients to assign benefits directly to a provider at the time of service, patients would be protected from unnecessary payment disputes and collection actions.

Thank you again for issuing strong regulations to protect patient interests. We look forward to working with you to further improve patient access to appropriate, high quality emergency services. Please contact me or EDPMA's Executive Director, Linda Ayers, at (703) 610-9033 if we can be of any assistance on this topic or any other area.

Sincerely,



Randy Pilgrim, MD, FACEP
Chair, EDPMA Board of Directors