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Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and PatientProtections

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General Comment

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The Louisiana Department of Insurance (LDOI) is submitting the following comment in response to the U.S. Department of Health and Human Services (HHS) Interim Final Regulation on Patient Protection and Affordable Care Act (PPACA): Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections.

It is uncertain whether the term "limitation," as it is used in §2719A(b)(1)(C)(ii)(I), is intended to apply to administrative requirements, such as submission of prior notice, or whether "limitation" includes differing levels of benefit coverage of emergency services based upon the network status of the provider such that a patient would be subject to balance billing from out-of-network providers. If "limitation" includes the differing levels of benefit coverage of emergency services for out-of-network providers, such out-of-network providers would be prohibited from balance billing the insured.

As proposed, this Regulation interprets §2719A(b)(1)(C)(ii)(I) to clearly allow the out-of-network provider to balance bill 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)…" Furthermore, the proposed Regulation properly states that the purpose of the protections of PPACA would be defeated if a plan or issuer pays an unreasonable amount to an out-of-network provider thereby increasing the balance billing amount to the insured. Additionally, this proposed Regulation does not limit a provider's ability to set the amount he charges for an emergency service which creates the "excess amount," referenced in this proposed Regulation. It does not contain a provider anti-abuse provision and does not anticipate the ability of a provider to increase his charges and collect the excess of the amount of the out-of-network provider charges over the amounts the plan or issuer is required to pay under paragraph (b)(3)(i). Thus, the incentive for increased and unreasonable billing practices by out-of-network providers in order to create an "excess amount" could circumvent the intent of this patient protection in PPACA. In essence, without clarifying that "limitation" applies to differing levels of benefit coverage for emergency services, an out-of-network provider can continually impose unlimited excess amounts that can be balance billed to the insured. Such practice would completely negate the intent and purpose of this patient protection provision of PPACA.

For example, prior to the enactment of PPACA, a provider's charges for an emergency service could have been $1,000.00. The provider would have submitted the bill to the plan or issuer, the bill would have been adjudicated and the provider reimbursed $300.00. The provider would have then balanced billed the patient for $700.00. After the enactment of PPACA, the provider decides to increase his charge for the same emergency service, as mentioned above, to $2,000. The plan or issuer then adjudicates the claim and pays the greatest of the three amounts enumerated in this Regulation which may total $800.00. This ensures that he makes an additional profit of $500.00 from the patient and the patient is now liable for a total $1,200.00.

The LDOI is recommending that clarification and guidance is needed from HHS on the interim final Regulation. To permit balance billing in the Regulation eliminates any patient protection for the insured in an emergency situation. Furthermore, to not provide an anti-abuse provision for out-of-network providers creates a financial disincentive for insureds to receive emergency services and does not protect patients from substantial financial burden. PPACA recognized that prior authorization only serves as an obstacle to an insured receiving emergency services and therefore removed any such requirement. In furtherance of that laudable objective, HHS should clarify that an out-of-network provider is prohibited from balance billing the insured once the out-of-network provider has received the copayment or coinsurance from the insured and the greatest of the three amounts enumerated in this Regulation from the plan or issuer. Allowing balance billing creates a substantial financial burden and may discourage patients from obtaining the care needed in an emergency situation.

Attachments

HHS-OS-2010-0014-DRAFT-0068.1: Comment on FR Doc # 2010-15278