TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

August 27, 2010

Mr. Jim Mayhew
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-994-IFC
P.O. Box 8016
Baltimore, MD 21244-1850
RIN 0991-AB69

Re: Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule; as published in the Federal Register on June 28, 2010.

Dear Mr. Mayhew:

The Texas Medical Association (TMA) appreciates this opportunity to comment on proposed regulations relating to restrictions on rescissions and health plan coverage of out-of-network emergency services, which are statutorily authorized under Sections 2712 and 2719A of the Public Health Services Act, respectively, as amended by the Patient Protection and Affordable Care Act (PPACA).

TMA is a private voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its mission is to "Improve the health of all Texans." Its almost 46,000 members practice in all fields of medical specialization. It is located in Austin and has 119 component county medical societies around the state.

TMA has a keen interest in advocating for consumer and patient protection laws promoting fairness and transparency in the health insurance industry. Establishing protections against unjustified (i.e., non-fraud induced) rescissions at the state level has been a legislative priority for TMA in the past as part of its proposed Health Insurance Code of Conduct reforms. Accordingly, TMA strongly contends that establishing meaningful protections against unwarranted rescissions (at both the federal and state level) is vital to ensuring that consumers/patients: (1) have health insurance coverage upon which they may rely, (2) are not unfairly penalized for unintentional errors or omissions contained within their insurance applications, and (3) are not unfairly penalized for a historical diagnosis unrelated to the current condition upon which the rescission was initiated.

Additionally, TMA has long-recognized the need for patient access to and health plan coverage of emergency services. Thus, TMA generally supports patient protections directed at broadening patient coverage for emergency services; however, TMA urges the Department of Health and

Human Services' (DHHS), Department of Labor, and Department of the Treasury: (1) to be circumspect in formulating and implementing the cost-sharing protections stemming from Section 2719A of the Public Health Services Act and (2) to continue to acknowledge the vitally important need for retention of the physician's right to balance bill for his services (as discussed in more detail below).

TMA appreciates the Departments' efforts in drafting its request for comments and in appropriately seeking and considering stakeholder responses regarding restrictions on rescissions and patient protections pertaining to out-of-network coverage for emergency services. TMA, therefore, respectfully offers the following comments on the proposed and final rules on rescissions and out-of-network emergency services coverage, as published in the Federal Register on June 28, 2010.

## I. Prohibition on Rescissions (26 CFR 54.9815-2712T, 29 CFR 2590.715-2712, 45 CFR 147.128)[1]

First, TMA strongly agrees with the Departments' statements and findings regarding the need for protections against non-fraud related rescissions of health insurance coverage, as set forth in the preamble to the rules. Robust protections from unwarranted rescissions are necessary to protect individuals who might otherwise be subjected to rescissions each year (i.e., approximately 10,700 people) from the financial devastation that often accompanies the sudden and unexpected loss of health insurance coverage.[2] As the preamble to the proposed rule states "these … regulations implement the statutory provision enacted by Congress to protect the most vulnerable Americans, those that incur substantial medical expenses due to a serious medical condition … by ensuring that such individuals do not unjustly lose health coverage by a rescission."[3]

Notably, the statutory provisions and the rules provide two main protections to consumers: (1) a requirement that the plan provide notice to the covered person prior to rescinding coverage and (2) a requirement that rescissions be limited to instances of fraud and intentional misrepresentation. Section 2712 of the Public Health Services Act does not specify a particular timeframe for the notice requirement. TMA, however, supports the Departments' promulgation of a minimum notice period of 30 calendar days, as contained within 45 CFR 147.128(a). TMA strongly contends that the inclusion of a *reasonable* notice period in the rules is important to effectuating the consumer protection-driven intent of the law. Without a sufficient notice period, consumers may be faced with an immediate interruption in health insurance coverage without adequate, if any, warning. Such an interruption could be devastating to an individual's finances, since the insurer would no longer be responsible for the consumer's medical claims (including those claims that had previously been accepted and/or paid). Additionally, the interruption in coverage could detrimentally affect the individual's health if he or she foregoes necessary treatment during that period.[4] Thus, it is

[1] Note that that all references in this letter referring to 45 CFR 147.128 apply to the corresponding language contained within 26 CFR 54.9815-2712T and 29 CFR 2590.715-2712.

[2] Note that this number is cited in the preamble to the rules. *See* 75 Fed. Reg. 37208 in which it states that "the NAIC Regulatory Framework Task Force collected data on 52 companies covering the period 2004-2008, and found that rescissions averaged 1.46 per thousand policies in force. This estimate implies that there are approximately 10,700 rescissions per year."

[3] 75 Fed. Reg. 37198.

[4] *See* 75 Fed. Reg. 37208-37209, stating "Gaps in health insurance, even if brief, can have significant health and financial consequences. A survey from the Commonwealth Fund found that about three of five adults with any time uninsured said they had not received needed health care in the past year because of costs—more than two times the rate

imperative that individuals be afforded sufficient time to contest a rescission or to explore other options for coverage while the plan is considering rescinding coverage. The 30-calendar-day notice requirement of 45 CFR 147.128(a) provides the individual with much-needed time to prepare for any rescission-related fallout. Any period of time less than 30 days would be insufficient for the individual to seek alternate coverage and would, therefore, be unreasonable.

Next, TMA supports the Department's conclusion concerning rescissions as expressed in Example 1 in 45 CFR 147.128(a)(3). In Example 1, the Department establishes a scenario under which a plan rescinds coverage after an individual is diagnosed with breast cancer. The insurer's decision to rescind is based upon the individual's failure to disclose (in a medical history questionnaire that asked "is there anything else relevant to your health that we should know") visits with a psychologist that occurred six years prior to the individual's breast cancer diagnosis. The rule states that rescinding coverage under this set of facts would be improper, because the individual's failure to disclose the psychologist visits was inadvertent. Further, the rule concludes: "Therefore, it was not fraudulent or an intentional misrepresentation of material fact." TMA supports this interpretation and application of the rule's fraud and "intentional misrepresentation" language. The conclusion to Example 1 provides valuable guidance to insurers regarding the Departments' position on the scope of the rescission restrictions and ensures that consumers are not subject to rescissions based upon innocent errors or omissions (i.e., representations made without the intent to deceive the insurer).

Additionally, TMA supports the language in the preamble acknowledging a history of "some questionable practices … [in the area of rescissions] including insurance companies rescinding coverage even when discrepancies are unintentional or caused by others, for conditions that are unknown to policyholders, and *for discrepancies unrelated to medical conditions for which patients sought medical care*."[5] (emphasis added). Importantly, the proposed rules address each of the listed "questionable practices," with the exception of the last practice (i.e, rescissions based upon discrepancies unrelated to the medical condition for which the patient sought care). In order to address this concern, TMA recommends that the Departments clarify that an insurer is prohibited from rescinding coverage unless the intentional misrepresentation of material fact occurring in the application is directly related to the individual's medical claim(s). To illustrate this point, in Example 1, the plan could only rescind coverage if the patient's omission was related to a past history with breast cancer.[6]

---

of adults who were insured all year. Further 44 percent of respondents who had experienced any coverage break during the prior year said they had failed to go to a doctor or a clinic when they had a medical problem because of costs, compared with 15 percent of adults who did not experience such breaks."

[5] 75 Fed. Reg. 37208.

[6] Note that allegations of rescissions based upon omissions completely unrelated to the current diagnosis have occurred in Texas, as well as other states. For example, as noted in a January 23, 2009 TMA press release: "The *Fort Worth Star-Telegram* reported last summer about a Waxahachie woman who was diagnosed with breast cancer and was scheduled for a double mastectomy. But days before the surgery her insurance company, Blue Cross and Blue Shield of Texas, canceled her insurance. Its reason? She did not disclose a prior medical condition — acne — on her insurance application. She asked her congressman for help. Months later, at the congressman's urging, Blue Cross reinstated the patient's insurance, and she rescheduled her surgery. A spokeswoman for Blue Cross said health privacy laws limit her ability to discuss the patient's situation. But she told the Star-Telegram that patients have a right to appeal policy cancellations. Meanwhile, the Waxahachie patient believes her delay in care caused by her health insurer's red tape may eventually cost her life." *See* http://www.texmed.org/Template.aspx?id=7411

Finally, TMA notes that Section 2712 of the Public Health Services Act and the proposed rules seek to provide a *basic* level of protection from unjust rescissions (i.e., those rescissions that are not grounded upon fraud or intentional misrepresentations made in the completion of insurance applications). Given the fundamental nature of the protections afforded under Section 2712 of the Public Health Services Act and the attendant rules, it is quite possible that state laws may impose rescission-related consumer protection measures that exceed the new federal requirements. To ensure that insurers properly conduct their underwriting *prior* to issuance of coverage, rather than engaging in the type of "post-claims underwriting"[7] that sometimes occurs with rescissions, it is imperative that any more stringent state laws (including common law) continue be given full effect (even after the effective date of the federal rules). To that end, TMA strongly supports the Departments' inclusion of an express provision in the rules (i.e., 45 CFR 147.128(b)) sanctioning the applicability of other more stringent state law, as well as other federal law. 45 CFR 147.128(b) is important, because it clarifies the Department's intent to create a federal floor, rather than a ceiling with regard to its restrictions on rescissions.

## II. Patient Protections (26 CFR 54.9815-2719AT, 29 CFR 2590.715-2719A, and 45 CFR 147.138)[8]

### A. General Rules Regarding Prior Authorizations/Out-of-Network Payments (45 CFR 147.138(b)(2))

Next, Section 45 CFR 147.138(b)(2) of the rules requires non-grandfathered group health plans (and/or health insurance issuers offering group or individual health insurance) that provide emergency services benefits to provide coverage for emergency services: (1) without the need for a prior authorization (even for out-of-network services) and (2) without regard to whether the health care provider is a participating network provider. TMA supports these basic emergency service coverage requirements. These provisions of the rule largely track the underlying law (i.e., Section 2719A) and are important steps towards ensuring that many patients have basic insurance coverage for emergency services without being penalized for a plan's inadequate networks and/or utilizing a non-plan participating provider.

Additionally, the rule ensures that the patient's access to benefits for emergency services is not mired with undue or cumbersome administrative burdens (such as prior authorization requirements imposed either in or out-of-network). As stated in the preamble, "these provisions will ensure that patients get [access to benefits for] emergency care when they need it, especially in situations where prior authorization cannot be obtained due to exigent circumstances or an in-network provider is not available to provide the services."[9]

In emergencies, time is often of the essence. Patients do not always have sufficient time to adhere to a plan's requirements for prior authorizations, confirm the provider's in-network status, or locate (or delay treatment for) an available in-network provider. Section 2719A of the Public Health Services Act and the proposed rules properly acknowledge and attempt to address the financial

[7] *See* 75 Fed. Reg. 37208.
[8] Note that all references in this letter referring to 45 CFR 147.138 apply to the corresponding language in 26 CFR 54.9815-2719AT and 29 CFR 2590.715-2719A.
[9] *See* 75 Fed. Reg. 37198.

implications associated with this timing issue; thereby recognizing the primacy of patient access to benefits for emergency medical care over the plan's administrative requirements.

Further, TMA House of Delegates' policy[10] supports the notion of requiring health plans to provide *fair* payment for services rendered under the Emergency Medical Treatment and Labor Act mandate (without limiting or restricted balance billing for out-of-network services).[11] Removing prior authorization barriers and extending coverage to care provided by out-of-network providers are important steps towards this end (by at least ensuring some payment from the health plan). Section (b)(3) of the proposed rules, however, touches upon the *fairness* of that payment and the continued need for and right to balance bill (as discussed more fully below).

### B. Cost-sharing Requirements (45 CFR 147.138 (b)(3))

TMA supports Section 2719A(b)(1)(C)(ii)(II) of the Public Health Services Act, as amended by PPACA, which requires health plans to apply the same cost-sharing requirements (i.e., coinsurance and copayments) for emergency services provided out-of-network as the cost-sharing that would be applied if the services were provided in-network. Additionally, TMA supports the basic goal of Section 2719A and of the rule's cost-sharing requirements, which is to alleviate some of the financial burden that patients incur when plans impose differing cost-sharing requirements for in-network and out-of-network emergency services.

As the preamble to the rule acknowledges:

> Implementing reduced cost sharing for the use of in-network providers provides financial incentive for enrollees to use these providers, with whom plans often have lower-cost contractual arrangements. In emergency situations, however, the choice of an in-network provider may not be available—for example, when a patient is some distance from his or her local provider networks or when an ambulance transports a patient to the nearest hospital which may not have contractual arrangements with the person's insurer. In these situations, the differing copayment or coninsurance arrangements could place a substantial financial burden on the patient. These … regulations eliminate this disparity in out-of-pocket burden for enrollees, leading to potentially substantial financial benefit.[12]

Certainly, the goal of creating cost-sharing requirements that do not penalize patients for utilizing out-of-network emergency services is laudable. However, TMA strongly encourages the Department to carefully consider the best and most appropriate means of achieving this goal, as set forth in its proposed regulations.

---

[10] TMA House of Delegates Policy. 130.019 Emergency Medical Treatment and Active Labor Act: The Texas Medical Association supports requirements for health care payment plans to provide fair payment for services rendered under the Emergency Medical Treatment and Active Labor Act mandate and opposes efforts to limit or restrict balance billing of patients for out-of-network physician services (Amended Res. 402-A-09).

[11] Note that, as acknowledged in the preamble to the rule, "In applying the rules relating to emergency services, the statute and these interim final regulations define the terms emergency medical condition, emergency services and stabilize. These terms are defined generally in accordance with their meaning under Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act. There are, however, some variances from the EMTALA definitions." *See* 75 Fed. Reg. 37212.

[12] 75 Fed. Reg. 37214.

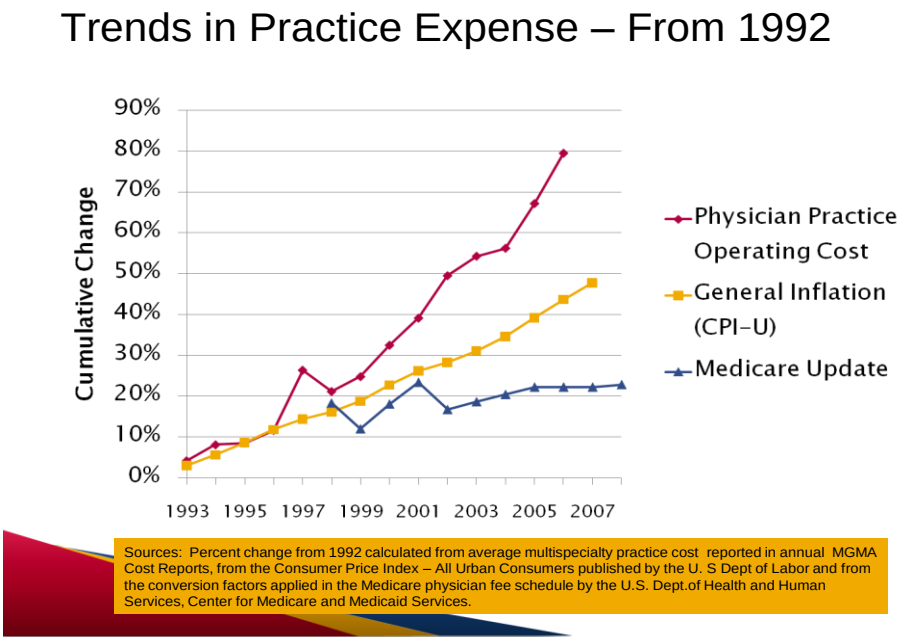
1. **Balance Billing (45 CFR 147.138 (b)(3)(i))**

First, TMA applauds the Department for appropriately recognizing that the provider's right to balance bill is unaffected by the cost-sharing limitations imposed on plans under Section 2719A of the Public Health Services Act. Further, TMA supports the inclusion of express language safeguarding the provider's right to balance bill, as included in the rule. Specifically, the rule states:

> Any cost-sharing requirement expressed as a copayment amount or co-insurance rate imposed with respect to a participant, beneficiary, or enrollee for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant, beneficiary, or enrollee if the services were provided in-network. *However, a participant, beneficiary, or enrollee 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).* (emphasis added*).*

The aforementioned italicized language, contained within the rule, properly acknowledges the legislative intent that balance billing not be considered part of the participant's cost-sharing that is restricted under the law. Section 2719A of the Public Health Services Act specifically identifies coinsurance and copayments when referring to cost-sharing. Additionally, as properly acknowledged in the preamble to the rule, "Section 1302(c)(3)(B) of the Affordable Care Act excludes such balance billing amounts from the definition of cost sharing…" Thus, the plain language of the underlying law evinces a clear intent to protect the provider's ability to bill for the difference between his charges and the amounts collected from the participant in the form of coinsurance/copayments and the plan in the form of at least the minimum out-of-network payment mandated by the rule.

Further public policy supports the continued ability for physicians to balance bill. Without safeguarding the physician's ability to balance bill, the physician would be forced to accept the minimums established by the regulations. The regulations would, therefore, effectively act in the capacity of a de facto involuntary contract for out-of-network services and severely restrict the physician's ability to set a value for his own services. It is imperative that the Departments recognize that physicians must act as any other rational business decisionmaker and evaluate whether to sign a health plan's contract based upon the terms and rates offered by each plan. The physician's acceptance of a given contract will depend upon many factors, including the reasonableness of the plan's offer and the revenue needed by the physician to pay overhead expenses. Without the ability to make such an assessment and to set his own rates (i.e., to balance bill), a physician may simply be unable to sustain his practice. As the diagram below illustrates, Medicare rates have not kept pace with physician practice operating costs.




Consequently, mandating that health plans pay a minimum for out-of-network emergency services (e.g., the greatest of discounted in-network rates, Medicare rates, or the plan's usual, customary and reasonable rate) and simultaneously restricting the physician's ability to balance bill would likely negatively impact the overall supply of available physicians. Further, the plans would have little, if any, incentive to create a network or offer reasonable contracts to physicians. Certainly, decreasing the supply of physicians is not the result intended by this consumer protection law (nor is any restriction on balance billing specifically contemplated by the law, as previously noted). Thus, TMA strongly supports the Departments' inclusion of the language expressly recognizing the physician's continued and unrestricted ability to balance bill the patient for his charges that are in excess of the plan's minimum out-of-network payment and the participant's copayments and coinsurance. Further, TMA urges the Department to retain the language of 45 CFR 147.138(b)(3)(i) as it relates to balance billing.

**2. Minimum Out-of-Network Payments (45 CFR 147.138(b)(3)(A)-(C))**

Next, the preamble to the rule states that because "it would defeat the purpose of the protections in the statute if a plan or issuer paid an unreasonably low amount to a provider, even while limiting the coinsurance or copayment associated with that amount to in-network amounts," the rule establishes a minimum "reasonable amount to be paid for services by some objective standard."[13] The "objective standards" established by the rule include the greatest of three possible amounts, namely: (1) the amount (or median of the amount) negotiated with in-network providers for the emergency services furnished; (2) 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 usual, customary and reasonable charges), but substituting the in-network cost-sharing provisions for the

[13] 75 Fed. Reg. 37194.

out-of-network cost-sharing provisions; and (3) the amount that would be paid under Medicare for the emergency services.[14]

While, as previously stated, TMA supports "requirements for health care payment plans to provide fair payment for services rendered under the Emergency Medical Treatment and Active Labor Act" and TMA appreciates the Departments' efforts to establish a minimum "reasonable amount" to be paid by plans and insurers, we have concerns with the three amounts delineated in the rule (even if—as the rule correctly specifies—the amounts are used as a floor (not a ceiling) for plan payments and the physician is still permitted to balance bill without limitation).

First, it should be noted that two of the three rates contained within 45 CFR 147.138(b)(3)(A)-(C) are largely within the plan's control and are, therefore, subject to plan data manipulation. Clearly, the plan makes the ultimate decision on what rates to accept in-network under the first methodology (i.e., Section 147.138(b)(3)(A)). Additionally, the second methodology (i.e., use of the usual, customary, and reasonable (UCR) amount) is determined solely by the plan based upon internal and/or external data sources available to the carriers. Recent events related to the use of one external data source, Ingenix, a wholly-owned subsidiary of UnitedHealth Group, illustrate the inherent conflicts that may characterize and problems that may plague insurer-determined out-of-network payment amounts. In 2008, Ingenix was the subject of an investigation by the New York Attorney General Andrew Cuomo (and a later lawsuit initiated by the American Medical Association). Upon completing his investigation, the Attorney General determined that rates established under Ingenix had been unfairly set, and many insurers subsequently agreed to discontinue use of the Ingenix database upon the establishment of a new independent database.[15]

Thus, insurer-controlled measures have been demonstrated to lack reliability or objectivity as indicators of what is a "reasonable" amount for a plan to pay providers for out-of-network emergency services (even if the plan must pay the *greatest* of the three computations). TMA, however, appreciates the Departments' efforts to reduce gaming of these computations by (1) requiring use of the median of the in-network rates (rather than the average, which is more easily affected by outliers) and (2) prohibiting further reduction of the UCR by disallowing reductions for out-of-network cost sharing that generally apply under the plan or health insurance coverage with respect to out-of-network services.[16] However, it is important to note, at the present time, due to the position taken by most carriers that their method of calculating payments (e.g., UCR) is proprietary data, the plans still have ultimate control over these methodologies and there is little or no transparency associated with these numbers. Thus, the payments cannot be properly reviewed by the consumer or the provider to ensure that the plan is, in fact, complying with the rule and paying (at a minimum) the *greatest* of the three computations in Section 147.138(b)(3).

Next, TMA supports the Departments' desire to include a method for calculating the minimum out-of-network payment that is independent of the plans, as intended with the inclusion of Section 147.138(b)(3)(C). TMA agrees that it is critical that the rule contain a method for calculating out-of-network payments that is easily quantifiable, publicly available, and independently formulated so that a true, transparent floor for out-of-network payments for emergency services may be

[14] *Id*.
[15] *See* Emily Berry, "New database for out-of-network pay set to replace disputed Ingenix system," American Medical News, Nov. 9, 2009, *available at*: http://www.ama-assn.org/amednews/2009/11/09/bil21109.htm
[16] *See* Section 147.138(b)(3)(B).

established. Finding the appropriate methodology, however, is easier said than done. At the present time, Medicare appears to be the only method of computation that even attempts to meet the aforementioned description. However, it is important to note that Medicare is *not* a reflection of prevailing market rates for out-of-network emergency services. Medicare rates fluctuate based upon political factors and other factors entirely unrelated to the commercial insurance market. The ever-present, recurring threat of 21% cuts related to the Sustainable Growth Rate (SGR) is illustrative of the clear and growing disconnect between and among Medicare, the commercial insurance market, and the costs that medical practices incur when treating patients.

Further, the Medicare rates referenced in the rule lack the specificity necessary to provide guidance to plans/issuers and providers as to the true basis for the Medicare-determined component of the floor established by the rules. The regulations include the basic citation for the Medicare payment provisions (i.e., part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.). Presumably, the Departments are referring to 100% of the participating provider's Medicare fee schedule, as contained within Part A and B. However, it is important for the Departments to note that other fee schedules references are included within the general citation, such as the non-participating provider fee schedule (i.e., a limiting charge of 115% of 95% Medicare fee schedule contained within 42 U.S.C.1395w-4). Thus, TMA seeks clarification as to the Department's intended application of the provider fee schedule.

Given all of the aforementioned difficulties associated with using Medicare as one of the amounts for establishing a floor for out-of-network emergency services payments, TMA stresses the importance of the Department revisiting this issue as more information regarding out-of-network rates becomes publicly available and other independent databases, such as the FAIR (Fair and Independent Research) Health Database (resulting from the settlement over Ingenix's alleged abuses) become operational.

Finally, to ensure plan/issuer compliance with the emergency services' coverage and payment provisions of the rule, TMA recommends that the DHHS regularly audit the determinations of out-of-network payment minimums, mandate reporting of such minimums, and require such reporting to be updated on a quarterly basis. These actions would provide much-needed transparency to the process.

## III. Conclusion

Once again, TMA thanks you for the opportunity to provide these comments. If you should have any questions or need any additional information, please do not hesitate to contact me or the following staff of the Texas Medical Association: Lee A. Spangler, JD, TMA Vice President, Division of Medical Economics; Patricia Kolodzey, TMA Associate Director, Legislative Affairs; or Kelly Walla, JD, LLM, TMA Associate General Counsel at TMA's main number 512-370-1300.

Sincerely,

Susan Bailey, MD

President
Texas Medical Association