



December 9, 2015

Mr. Andy Slavitt
Acting Administrator Centers for Medicare and Medicaid
Centers for Medicare & Medicaid Services
Department of Health and Human Services
445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections under the Affordable Care Act-CMS 9993-F

Dear Administrator Slavitt:

On behalf of more than 34,000 members of the American College of Emergency Physicians (ACEP), and the Emergency Department Practice Management Association (EDPMA) a trade association representing emergency physician groups and their partners who treat or support about half of the 136 million patient visits to the emergency department each year, we want to express our objections to the revised language of these rules as they pertain to emergency services.

ACEP and EDPMA believe that these Final Regulations, specifically the language pertaining to the so-called 'greatest of three standards' for health plan benefits for out-of-network emergency care services, represent the greatest threat to the financial viability of the emergency care safety net, and patient access to qualified emergency physicians and emergency department on-call specialists, that has EVER been proposed by federal regulators.

To say that many of the emergency physicians represented by ACEP and EDPMA are angered by this language, and feel betrayed by the staff of CMS' Center for Consumer Information and Insurance Oversight (CCIIO), would be a gross understatement. Our members and ACEP staff met in good faith with CCIIO staff on multiple occasions since the Interim Final Rules were first published in 2010.

In 2010, ACEP, the American Medical Association, the American Hospital Association, and several other organizations all objected to the greatest of three standards in our respective comment letters in response to the Interim Final Rule (IFR). It was clear then, and even more so now that we have claims evidence, that insurers would use their own proprietary data to reduce payment to physicians and shift financial liability to their enrollees for out-of-network services (OON). We predicted that unenforced standards for OON benefits in the IFRs would lead to this outcome. We urged your agencies to modify these standards to ensure that the benefits that enrollees paid for with their premiums were provided by their health plans, based on reasonable payment and objective standards consistent with the guiding principles in the PPACA (We believe its original name – Patient Protection and Affordable Care Act – should be retained rather than just referring to it as the ACA).

December 9, 2015

2

Because the IFR was effective in August of 2010, without the Agencies response to comments, ACEP initiated a series of meetings with CCIIO leadership to outline our concerns and we proposed a straightforward remedy through sub-regulatory guidance. Our task was made all the more difficult due to the revolving door leadership of CCIIO. Our written comments were addressed to Jay Angoff; our first meeting was with Steve Larsen, then Gary Cohen, Mike Hash, Mike Adelberg, and most recently with Kevin Counihan. Each time the leadership changed, we had to educate staff regarding our concerns.

During these meetings, ACEP has presented actual claims data that depict the impact of the unenforceable, non-transparent, and unreasonable ‘greatest of three benefit standards’ on health plan enrollees, who have been the victims of the transfer by plans of hundreds of millions of dollars in out-of-pocket liabilities. This represents a total failure to implement the “patient protections” that were promised in the Patient Protection and Affordable Care Act.

The language of both the IFR and the final regulations state- “it would defeat the purpose of the protection in the statute if a plan or issuer paid an unreasonably low amount to a provider...therefore, as provided in the IFR and these final regulations, a plan or issuer must pay a reasonable amount for emergency services by some objective standard.”

All we asked for at every one of our meetings with CCIIO was an objective standard by which benefits for OON emergency care services would be transparently determined, enforceable, reasonable, and market driven. Our proposal would have also addressed those charges by providers that were excessive, and would have minimized the financial impact and frequency of balance billing for OON services.

We remind you that insurers have a history of data manipulation. We all recall when the (then) Attorney General of New York Andrew Cuomo took on United Healthcare’s subsidiary Ingenix for manipulating charge data to under pay physicians and the company was fined \$300 million. Those funds were used to set up an open, non-profit database for charge data (Fair Health). Unfortunately, this final rule basically re-creates the same environment for insurers to use black box methods to determine physician payment.

We also want to remind you that in 2014, after we responded to your request and shared numerous EOBs with CCIIO leadership, the Center hired a contractor to review emergency medicine concerns about significant payment reductions by certain large insurers. The contractor interviewed our physician leaders as well as insurance company representatives. Meanwhile, CCIIO leadership changed hands for a 5th time, and when we finally got the report through a FOIA request in July, 2015, we were surprised that the results of the investigation produced a weak, qualitative study with equivocal findings, instead of a quantitative analysis of the claims data.

These recently released Final Regulations came as a surprise to ACEP, as we were led to believe by Kevin Counihan, the current Director of the CCIIO, in our most recent meeting, that finalizing these regulations was low on the list of priorities for CMS and they were not on a list of CMS regulations under development. Further, at this same meeting on July 21, 2015, Mr. Counihan expressed concern about the transfer of financial liability to patients and expressed a willingness to give serious consideration to the recommendations that ACEP made for guidance regarding the application of the benefit standards, and agreed to meet with us again once he had time to review our data. He later reneged on all these commitments.

The Final Rules

For the Agencies to respond to our repeated and reasonable calls for insurers to use transparent, verifiable charge data by saying in the final rule that “the Departments believe that this concern is addressed by the greatest of three amounts specified” is disingenuous at best, as no requirement was ever made on your part to ensure transparency in establishing physician payment.

Instead, your agencies finalized the rules, substituting language that is even more likely to undermine benefits and destabilize an already overwhelmed and underfunded emergency care safety net. Gutting commercial health plan benefits for emergency physician and ED on-call specialist out of network services, and ultimately undermining in-network contracting rates, will have deleterious consequences. In addition, by adding language promoting a prohibition against balance billing for these claims in the face of a set of benefit standards that effectively permit plans to pay whatever benefits they choose, you have exceeded the authority provided by Congress in the PPACA, which recognized the right of out of network providers to receive the reasonable value of their services through, if necessary, balance billing.

What stands out as another disturbing element of these wording changes to the Interim Final Regulations (pg. 37194) is the substitution of the word ‘amount’ for ‘charges’ in the second of the greatest of three standards. The language of the examples originally said: “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 charges)”. The fact that the language of this example was revised in the Final Regulation from ‘usual and customary charges’ to ‘usual and customary amount’ was not even mentioned). It is as if the prior language never existed. Our sensitivity to this change reflects the fact that the original language referenced the historical behavior of most payers in using a benefit standard based on the long standing market use of usual and customary charges as the basis for establishing physician and hospital payment for OON services.

Now that the final rules use language that allows plans to once again use data they control to craft payments that are MUCH lower, the plans have been pushing CMS and others to eliminate any reference to Usual and Customary Charges altogether. It appears to the provider community that this is exactly what your three Departments have condoned and facilitated.

Likewise, health plans have been advocating for the prohibition of balance billing, and that is just what the Final Regulations promote. These Final Regulations could not have been more favorable to health plans if they were written by the plans themselves. It feels like the ten meetings that ACEP had with CMS to address the deficiencies with these interim regulations never happened, and that the numerous letters from ACEP, the AMA, state medical societies, EDPMA, the AHA, and others were never given the slightest bit of credence.

In addition, these new regulations reiterate a prior Department of Labor interpretation that if States prohibit balance billing, then plans don’t even have to consider the OON benefit standards in the PPACA. In support of the Final Regulations, the Departments allege that the greatest of three standards adequately address the concerns expressed by ACEP and others about the lack of transparency in plan benefits for OON services. THEY DO NOT. How you conclude that transparency is supported by rules that allow plans to use an undeclared, unpublished, self-determined methodology for choosing the ‘reasonable amount’ for an OON benefit, or to use the ‘median amount negotiated with in-network providers’ when these contracted rates are protected by non-disclosure agreements and are unavailable to either provider or regulators, begs credulity. Most importantly, these Final Rules completely ignore one of the most

December 9, 2015

4

important patient protections outlined in the Patient Protection and Affordable Care Act and the IFRs, which is access to emergency care.

Patient protections are undermined when commercial plans can pay a benefit for these services that is inadequate to sustain an already frayed emergency care safety net, especially in the context of a balance billing prohibition. Also ignored in these Final Regulations is the fact that a non-transparent and unenforceable set of standards for OON emergency care benefits undermines any incentive health plans may have to negotiate fair contracts with physicians and other health care providers for these services, which of course leads to more balance billing in states where there is no current prohibition. In light of the EMTALA obligation to provide emergency care regardless of payment, these Final Regulations, by allowing plans to unilaterally determine the reasonable value of these services, encourage an unconstitutional taking of physician and hospital services. In the plainest language we can use: these proposed Final Regulations pander to the profit motives of health plans, and they are biased and ill advised. In the strongest terms possible, we recommend that you reconsider this language in the Final Regulations, published or not, before you do irreparable damage to the emergency care safety net on which more than 136 million citizens a year, and health plans, for that matter, rely.

If you have any questions, please contact Barbara Tomar, ACEP's Federal Affairs Director btomar@acep.org or Elizabeth Mundinger, EDPMA's Executive Director at emundinger@edpma.org.

Sincerely,



Jay A. Kaplan, MD, FACEP
President, ACEP



Timothy Seay, MD, FACEP
Chair, EDPMA

Cc: Sylvia Mathews Burwell, Secretary, DHHS
Kevin Counihan, Ass't Administrator and Director, CCIIO, CMS
Phyllis C. Borzi, Ass't Secretary, EBSA, DOL
Elizabeth Schumacher, EBSA, DOL
Anne Wall, Dep. Undersecretary for Federal Affairs, IRS/Treasury
Karen Levin, IRS, Treasury
Rep. Raul Ruiz, Member, U.S. House of Representatives
Rep. Joe Heck, Member, U.S. House of Representatives
Rep. Jared Huffman, Member, U.S. House of Representatives
Rick Pollack, President, American Hospital Association
Steven Stack, President, American Medical Association