



October 6, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9934-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Re: RIN 0938-AS95; CMS-9934-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018

Dear Administrator Slavitt:

We are writing on behalf of The Emergency Department Practice Management Association (EDPMA) and the 35,000 members of the American College of Emergency Physicians to express our concerns with some of the proposals in the Notice of Benefit and Payment Parameters for 2018. EDPMA is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year. We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

EDPMA and ACEP are concerned that this proposal could discourage access to a critically important essential health benefit – emergency care. We believe the proposal making patients liable for a percentage of the cost of an emergency department visit instead of a limited dollar amount will have the unintended effect of discouraging patients from seeking appropriate care in the emergency department. We believe the long-term effects are counter to the “triple aim” of population health, as patients’ health will suffer, leading toward greater propensity for complications and morbidity, and greater costs to the system.

We believe that healthcare services deemed “essential benefits” by the Affordable Care Act (ACA) should not only be covered by the Qualified Health Plans (QHPs), but should be fairly reimbursed. Unfortunately, the current proposal does not require adequate coverage. Instead, it encourages QHPs to shift much of the cost of emergency services onto consumers.

In order to ensure adequate coverage, QHPs, at minimum, must include needed patient protections such as:

- Requiring QHPs to exempt emergency services from patient deductibles;
- Requiring QHPs to pay a fair share of the overall cost of emergency care, including a consistent and transparent reimbursement rate for out-of-network care that is based on an objective standard such as a geographically adjusted, charge-based standard; and
- Requiring QHPs to provide an adequate network of emergency physicians that are accessible within a reasonable time and distance of each insureds’ residence.

1) EDPMA and ACEP Oppose the Proposed Maximum Patient Contribution for an Emergency Room Visit under Gold, Silver, and Bronze Policies

When defining the standardized insurance policy options under the Affordable Care Act, the proposal establishes the maximum amount a patient will be responsible for under a gold, silver, or bronze policy. In 2017, patients with a silver policy are responsible for no more than \$400 for an emergency room visit (after meeting their deductible), while those with a gold policy are not responsible for more than \$250 (after meeting their deductible). Under the 2018 proposal, CMS is instead limiting the patient responsibility to 20% (5% for certain silver plans).

This proposal poses a great deal of financial uncertainty for the patient who does not know the potential cost of care. If patients are liable for a percentage of the cost of an emergency room visit instead of a specific dollar amount, we believe patients who are concerned they might experience a large bill will be less likely to seek out necessary emergency care and are more likely to delay needed care.

For patients with bronze plans, emergency room services are subject to 50% cost sharing in 2017. Under the 2018 proposal, that figure drops to 40%. And, with the new HSA-eligible Bronze HDHP plans, patients would have no copay/cost sharing for emergency room services after meeting their deductible. While the proposed changes for bronze plans are moving in the right direction, as stated above, we believe the maximum contribution from the patient should be expressed as a limited dollar amount and not a percentage of the cost.

It is important to point out that the emergency department is often the most appropriate and cost-effective location to receive care. In 2013, the RAND Corporation released a study entitled “The Evolving Role of Emergency Departments in the United States,” that, among other things, explains why the emergency department is often the most appropriate venue for many patients. The RAND study found that emergency department physicians are the major decision makers in over half of an average hospital’s admissions and are critical in helping hospitals fulfill their statutory obligation to provide emergency care without regard to the ability to pay (i.e., EMTALA). Also, primary care

physicians increasingly rely on the emergency department to evaluate complex patients with potentially serious problems, while providing overflow and after-hours primary care. Additionally, emergency physicians are increasingly a viable resource as means to finding alternatives to costly hospitalization stays.

Unfortunately, the emergency department often is not seen as a cost-effective health care resource and key stabilization and decision point for patient disposition. Yet, the RAND report found that “an average inpatient admission costs ten times more than an average emergency department (ED) visit.” In many cases, a visit to the emergency department is not only appropriate – but the least costly alternative.

2) EDPMA and ACEP Urge Exemption of Emergency Services from the Deductible and Allowing Patients to Count Out-of-Network Payments for Emergency Care Toward Annual Limits on In-Network Cost Sharing

The vast majority of patient complaints about their financial liability for emergency care are not addressed by the proposed rule. When an insured patient is liable for a high proportion of a bill for emergency care, it is usually a reflection of the patient’s high deductible or copayment, and not the result of the provider’s charges. Yet, the proposed rule – which should specifically address the adequacy of the insurance coverage – does nothing to address these high deductibles for emergency care.

If the proposed rule intends to protect consumers from high bills for emergency care, including care provided by out-of-network providers, it should exempt emergency care from the deductible. At minimum, it should exempt Emergency Medical Treatment & Labor Act EMTALA-required care from the patient’s deductible. EDPMA and other organizations believe that this is consistent with not only the prudent layperson standard, but also the purpose and intent of the ACA. If emergency care is not exempted, consumers covered by a bronze plan – which low-income consumers often purchase – could end up paying their \$6650 deductible simply because they needed to go to the emergency department for a serious injury or illness.

Similar to provisions previously finalized by the agency¹, we also believe that cost sharing for out-of-network emergency room services – which is an essential health benefit – should count toward an enrollee’s in-network annual limit on cost sharing. Specifically, we urge CMS to require that each QHP that uses a provider network to count cost sharing paid by an enrollee for emergency services provided by an out-of-network emergency physician in an in-network setting towards the enrollee’s annual limitation on cost sharing.

¹ § 45 CFR 156.230(e)(1)

3) **EDPMA and ACEP Urge CMS to Include Provisions in the Rule that Ensure Compliance with the Greatest of Three Rule, including a Minimum Payment of the “Usual, Customary, and Reasonable” Rates for Out-of-Network Emergency Care**

We believe that consumers will be left paying more than their fair share for emergency care unless QHPs are required to pay a fair and reasonable reimbursement rate for out-of-network emergency care which we believe must go hand-in-hand with adequate network adequacy standards. With respect to out-of-network reimbursement standards, we assert that there must be an objective determination of ‘usual, customary and reasonable’ (UCR) reimbursement which is reflective of an independently-produced, commercially-available, statistically-significant and geographically-adjusted emergency physician charge database. Otherwise QHPs continue to have the ability to unilaterally manipulate and arbitrarily determine payment, which ultimately leaves patients with greater out-of-pocket exposure.

Unfortunately, emergency physicians are caught in an absurd catch-22 when it comes to out-of-network reimbursement. EMTALA mandates that everyone who visits the Emergency Department will be screened and stabilized without regard to their ability to pay. So, insurers are confident that their insured will receive high quality care from emergency physicians even when the insurers offer emergency physicians unreasonably low in-network and out-of-network reimbursement rates. In other words, lack of enforcement of the greatest of three standard **creates a strong disincentive for payers to reimburse for emergency care at a reasonable rate.**

The Emergency Department remains a key component of the healthcare safety net and, unfortunately, continues to assume a disproportionate share of the uncompensated and undercompensated care delivered in this country. Thus, ensuring fair payment by private insurers is imperative to protecting the safety net.

In order to protect access to emergency care, the federal government established – through regulations implemented in 2010 and reaffirmed in 2015 - minimum standards for out-of-network payments from private insurers to providers of emergency care. This standard is commonly referred to as the **Greatest-of-Three rule** which was implemented as part of the ACA. The Department of Health and Human Services, the Department of Labor, and the Treasury Department stated that “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.” Thus, “a plan or issuer must pay a reasonable amount for emergency services by some objective standard.” The Departments further provided that, at minimum, this reasonable amount is “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.”

Unfortunately, this standard has been unenforceable because insurers do not calculate their reimbursement rates in a consistent and transparent manner. The House and Senate Appropriations Committees of the U.S. Congress understand this problem. Both committees recently passed versions

of the 2017 Labor HHS Appropriations bill that include report language asking the Center for Consumer Information and Insurance Oversight (CCIIO) to provide guidance clarifying the meaning of usual, customary and reasonable (UCR) rates.

The House version of the language further states that the guidance may come in the form of Frequently Asked Questions, **“clarifying what constitutes the UCR amount using a transparent and fair standard, such as an independent unbiased charge database.”**

The proposed rule before us provides CMS with a great opportunity to provide guidance to insurers who want to offer QHPs. **We urge you to include in the final rule provisions that clarify that QHPs must reimburse for out-of-network emergency care, at minimum, at a UCR rate and that rate must be based on an independent transparent charge database.** As an example of legislative language that provides for such payments, see the state of Connecticut’s recently passed healthcare legislation that sets such out-of-network reimbursement for emergency services at the 80th percentile of a transparent database (PA 15-146 – <https://www.cga.ct.gov/2015/SUM/2015SUM00146-R03SB-00811-SUM.htm>). We urge you to adopt this same approach.

4) EDPMA and ACEP Urge CMS to Ensure that QHPS Offer Adequate Networks of Emergency Physicians

We appreciate that the proposal begins to address network adequacy. However, we are concerned that the standards might not require QHPs to offer an adequate number of in-network emergency physicians because insurers supposedly “cover” out-of-network emergency care.

Most emergency physicians would prefer to practice in-network, but when plans/insurers pay significantly less than costs, physician groups reasonably elect not to contract with those organizations. If insurers were required to have an adequate number of emergency physicians in network, the insurers would be forced to go to the negotiating table and negotiate a fair rate with these physicians who have lost their negotiating power due to EMTALA requirements.

Moreover, if an adequate network of emergency physicians is not required in the final rule, the consumer who faces an emergency, in many cases, would need to pay their deductible before getting any financial help from the QHP. On the other hand, if CMS requires QHPs to offer an adequate network of emergency physicians, consumers could find local in-network emergency physicians and would only be liable for their in-network copay. Thus, requiring an adequate network of emergency physicians is an important consumer protection.

5) EDPMA Raises Concerns with the NAIC Model on Network Adequacy

On many occasions, the proposal references model legislation for network adequacy drafted by the National Association of Insurance Commissioners (NAIC). We strongly oppose Section 7 (Requirements for Participating Facilities with Non-Participating Facility-Based Providers) because it undermines the Greatest of Three language of the ACA and encourages QHPs not to negotiate in good

faith with out-of-network physicians. We have attached our letter which fully describes why we oppose it.

6) Conclusion

In summary, EDPMA urges CMS to:

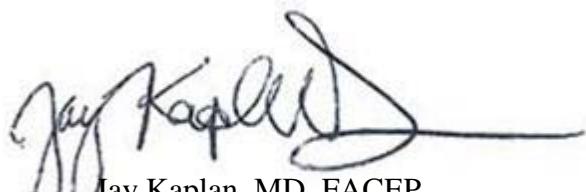
- 1) Express the proposed maximum patient contribution for an Emergency Room Visit under Gold, Silver, and Bronze Policies as a limited dollar amount (and not as a percentage of the cost of care),
- 2) Exempt emergency services from the deductible and allow patients to count out-of-network payments for emergency care toward annual limits on in-network cost sharing,
- 3) Clarify that, under the Greatest of Three rule, “Usual, Customary, and Reasonable” rates must be based on an objective transparent historical charge database,
- 4) Require an adequate network of emergency physicians, and
- 5) Discourage adoption of Section 7 of the NAIC Model on Network Adequacy.

Thank you for your consideration. Please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

Sincerely,



Timothy Seay, MD, FACEP
Chairman, EDPMA Board of Directors



Jay Kaplan, MD, FACEP
President, ACEP

ATTACHMENT



November 18, 2015

Kay Noonan, Esq.
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National Association of Insurance Commissioners (NAIC)
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Washington, DC 20001-1512

Transmitted via email: knoonan@naic.org

RE: Managed Care Plan Network Adequacy Model Act

Dear Ms. Noonan:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, **EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year.** We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

EDPMA shares the concern that insured patients are liable for an increasing share of their healthcare bills. However, current Section 7 ("Requirements for Participating Facilities with Non-Participating Facility-Based Providers") of the Managed Care Plan Network Adequacy Model Act ("Model") is not the solution to this problem. Section 7 would not only fail to address the crux of the problem – inadequate insurance coverage, it would create problematic incentives and disincentives that threaten access to emergency care. Therefore:

The EDPMA recommends that regulators remove Section 7 from the Model.

In the first place, Section 7 does not address the vast majority of patient complaints. In many cases, a large bill is simply a reflection of the patient's high deductible or copayment, an issue that the physician

(in-network or out-of-network) cannot control. EDPMA urges regulators to focus, instead, on the adequacy of the insurance coverage.

Secondly, although the Model recognizes the issues created by out-of-network billing, it does not discourage out-of-network billing for emergency care or address network adequacy for emergency care. For instance, the section addressing network adequacy does not require or encourage insurers to widen their networks of emergency physicians or otherwise require or encourage insurers to negotiate in good faith with emergency physicians for a fair in-network rate. Instead, it simply clarifies that the insurer can fulfill its obligations relating to emergency care through out-of-network providers and then reimburse those providers at the in-network rate (which might not be the result of fair negotiations).

In order to protect access to emergency care, the federal government established – through regulations implemented in 2010 and reaffirmed in 2015 - minimum standards for out-of-network payments from insurers to providers of emergency care (commonly referred to as the Greatest-of-Three rule). The Model does not meet those minimum standards. The Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service stated that “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.” Thus, “a plan or issuer must pay a reasonable amount for emergency services by some objective standard.” The Departments further provide that, at minimum, this reasonable amount is “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).” **Yet, the Model does not require this bare minimum payment required by federal law!** In a drafting note, the Model allows states to consider UCR charges, but does not require it as a bare minimum payment. We strongly urge you to remove Section 7 until the Model contains provisions that not only ensure the bare minimum payment already established by federal law, but also includes additional provisions ensuring fair payment. **We join with the American Medical Association and the American College of Emergency Physicians in urging regulators to specifically reference an independent transparent database that reflects UCR charges when establishing benchmarks for out-of-network reimbursement.**

Instead of relying on a database of UCR charges, the Model would base payment on in-network rates or a percentage of Medicare. This would create an absurd catch-22 for emergency physicians. The Emergency Medical Treatment & Labor Act (EMTALA) is a federal law that mandates that everyone who visits the Emergency Department will be evaluated and stabilized without regard to their ability to pay. So, insurers are confident that their insured will receive

high quality care from emergency physicians even when physicians are offered unreasonably low in-network and out-of-network reimbursement rates. In other words, **current law creates a strong disincentive to negotiating a fair in-network rate.** Yet, the Model relies heavily on the in-network rate, inappropriately implying that it is an appropriate measure of good faith negotiations resulting in a fair reimbursement rate.

This problem is compounded by the fact that EMTALA has created an environment in which emergency physicians provide more than their fair share of uncompensated care and patients who are covered by Medicare, Medicaid, and CHIP (which provide inadequate payment rates). As noted in the November 2, 2015 letter to NAIC from the American College of Emergency Physicians (ACEP), “[w]hile only 4% of physicians, [emergency physicians] provide 50% of all care given to Medicaid and CHIP patients and 67% of all care to uninsured patients.” The Emergency Department is a key component of the healthcare safety net and is taking on a greater share of uncompensated and undercompensated care. **Thus, ensuring fair payment for covered out-of-network emergency care is imperative to protect the safety net. Yet, the Model does not create any incentives to ensure good faith negotiations and fair pay.**

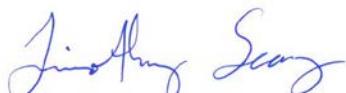
Calculating out-of-network payments based on a percentage of Medicare raises its own set of concerns. In the first place, Medicare rates were never intended to reflect the cost of care, the value of care, or UCR rates. They are simply a reflection of financial pressures created by federal budget constraints. Thus, it is no surprise that the American Medical Association stated in its letter to NAIC that this proposed reimbursement formula “would so significantly skew contract negotiations in favor of insurers that health care professionals who practice in hospitals would be unable to negotiate fair contracts. … [W]e are suggesting that in a world where the large insurers are merging and provider networks are narrowing, physicians need some leverage to negotiate a fair contract. A payment standard that falls below market rates and is not based on independent, out-of-network charge data will result in a market that cannot work for physicians, and in-turn patients.” Moreover, because Medicare rates are not based on the market, some specialties fair better than others under this payment scheme. Thus, each specialty has a different idea as to what percentage of Medicare represents fair payment. Using a payment based on Medicare would unfairly penalize some specialties.

And, finally, Section 7 – which would eliminate balance billing (an issue between provider and patient) and setting physician reimbursement rates - far exceeds the scope of a model on network adequacy and should not be within NAIC’s purview.

Please ensure that our comments are included in the record so state regulators are aware of our serious concerns regarding Section 7 when they consider adopting language included in the Model.

Thank you for your consideration. Please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

Sincerely,



Timothy Seay, MD, FACEP
Chairman, EDPMA Board of Directors