



August 3, 2010

Donald M. Berwick, MD, MPP, FRCP  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Attention: RIN 0991-AB69

**Re: PPACA Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections Interim Final Rule**

Dear Dr. Berwick:

On behalf of the American College of Emergency Physicians' (ACEP) more than 28,500 members, we are pleased to share our support and concerns on specific proposals in this Interim Final Rule that affect the practice of emergency medicine and the patients we serve. Our comments focus largely on patient protections and emergency services.

ACEP strongly supports the timely implementation of new federal policy that protects individuals who need health insurance the most, those with pre-existing conditions and those who may need extensive and expensive medical care. And, we are also pleased that the provisions apply to both employer-sponsored plans and insurance coverage sold in the individual market.

**Emergency Services**

ACEP has long supported three positions for emergency services that were included in PPACA: 1) universal adoption of the prudent layperson standard for individuals seeking care in the nation's emergency departments, 2) a ban on prior authorization for emergency care, including emergency services provided out-of-network, and, 3) a ban on greater restrictions on benefits and co-payments for out-of-network emergency services.

We largely support the language of the interim final rule with regard to implementation of these provisions. However, we have some concerns and seek clarification on these regulatory provisions as well.

First, we appreciate the clearly stated acknowledgement that allowing plans and insurers to pay emergency physicians whatever they see fit defeats the purpose of protecting patients from potentially large bills. In that light, we also support development of an objective standard to establish "fair payment". Insurers know that emergency physicians will see everyone who comes to the ED due to EMTALA responsibilities, and many leverage that fact to impose extremely low reimbursement rates. While a large majority of our members participate in nearly every plan or insurer network in their area, the primary reason they cite for not joining a plan's network is that the plan has arbitrarily offered an in-network payment rate that fails to cover the costs of providing the service.

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This forces the physicians to balance bill the patients, which often results in an unsatisfactory experience for everyone but the insurer.

One clarification that is needed in this regulation relates to the application of state laws that prohibit or limit balance billing for emergency department services. The Departments' more recent interim final rule, published on July 23<sup>rd</sup>, creates new patient protections for appeals of claims denials for group health plans and health insurance issuers. That rule will take effect for plan years starting September 23, 2010 but will not apply to residents in states that already have external review laws until July, 2011, giving those states time to adjust their own rules.

We believe that the same legal reasoning should apply regarding the effective date for the restrictions on cost-sharing for emergency departments so that these protections affect plans and insurers in every state (except currently grandfathered plans). Allowing state bans on balanced billing is inconsistent and incompatible with the statutory language of PPACA that permits balanced billing and we believe Federal law should prevail. We strongly support a uniform national standard with an effective date that provides states with time to make necessary revisions through their legislatures.

#### Payment for Out-of-Network Emergency Services

The IF rule requires that the plan or issuer pay for out-of-network emergency services (prior to imposing in-network cost-sharing) the greater of: 1) the median in-network rate; 2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services); or 3) the Medicare rate.

- Median in-network rate. Clarification is needed on how "network" will be defined in terms of the service area and how regulators will collect and verify proprietary payment data from plans and insurers. Also, how do the Departments propose to enforce use of reasonably drawn geographic areas for purposes of constructing a transparent median rate?
- Usual and customary reasonable rate. As noted in the IF rule, "there is wide variation in how plans and issuers determine in and out of network rates." The term "reasonable" is in the eye of the beholder. For many years, usual and customary rates referred to charges or a proportion of charges. This has changed in recent years and physicians, particularly emergency physicians, have had problems with the "black box" approach that commercial insurers have used to determine usual and customary "rates" for out of network providers. At this time, we are unaware of a national database that is widely available and provides timely data for objective comparisons of charges and/or costs that could be used to implement this part of the regulation. A new database, perhaps the FAIR health data that is currently being developed as a result of the settlement with Ingenix, may prove to be more timely and accurate, but any database used to establish usual and customary reasonable rates will require transparent validation, monitoring, and active enforcement by state and federal insurance officials.
- The Medicare rate. We assume that the Medicare payment rate with adjustments would be based on the location of the physician/hospital but seek clarification.

ACEP also asks that payment for out-of-network emergency physician services to be paid directly to the physician/group. Insurers often pay the patient and the physicians must then pursue payment from the patient which also leads to confusion, ill will, and most often non-payment for the out-of-network services. We believe that enrollees should be permitted to assign benefits to the emergency physician group. Assignment would make clear what the enrollee payment responsibilities are, i.e. any co- payments or deductibles, and not place them in between the payer and the provider.

If you have any questions about our comments and recommendations, please contact Barbara Tomar, ACEP's Federal Affairs Director at (202) 728-0610, ext. 3017.

Yours truly,

Angela F. Gardner, MD, FACEP  
President