

November 27, 2017

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters (NBPP) for 2019

Dear Administrator Verma:

On behalf of more than 37,000 members of the American College of Emergency Physicians (ACEP), we write to express our strong concerns with several of the provisions included in this rule as proposed.

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Health Insurance Issuer Standards under the Affordable Care Act, including Standards Related to Exchanges

Essential Health Benefits (EHBs) Package

The Affordable Care Act (ACA) requires individual and small group health insurance plans to cover ten broad categories of EHBs, of which emergency services is one, and the scope of coverage is determined by each state which can choose a benchmark plan for the coverage based on what a typical employer plan in their area includes.

For the 2019 plan year and beyond, HHS is proposing to provide states with additional flexibility in their selection of an EHB-benchmark plan, with the goal of increasing affordability of health insurance in the individual and small group markets. While ACEP strongly supports ensuring consumers in these markets have access to high-quality, affordable coverage options, we are very concerned with the proposed changes.

HHS proposes allowing a state to change its benchmark plan by:

1. selecting the EHB-benchmark plan that another state used for the 2017 plan year;
2. replacing one or more of the ten EHB categories of benefits in its own 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used the same year; or,
3. selecting a set of benefits that would become the State's EHB-benchmark plan, as long as that plan does not exceed the generosity of the most generous of among a set of comparison plans comprised of 2017 plan year benchmark plans, and is at least equal in scope of benefits to what is provided under a typical employer plan.

ACEP strongly opposes the proposed changes. Each state has its own unique market conditions, and the ACA's benchmark plan provisions have ensured that states can have a package of essential health benefits suited to its needs, while ensuring a floor of minimum coverage requirements. As a result of this flexibility, the items and services covered within a category can vary significantly from state to state.

As now proposed under #1 and #2, allowing a state to use the EHB-benchmark plan of any other state, and even allowing the mixing and matching of a particular category or categories and the benefits included within them from different states' benchmark plans, will quickly result in a race towards the bottom of states picking and choosing amongst the skimpiest offerings to design their own minimal coverage standard. States will be able to circumvent state benefit mandates and consumers can be left with a narrow set of benefits that do not ensure them access to the items and services they need to manage their health conditions. This will leave them paying even more out of pocket.

Additionally, the proposed rule would change the current definition of a "typical employer plan" on which a state must base its benchmark plan. As proposed, a "typical" plan would now be defined as an employer plan within a product with enrollment of at least 5,000 enrollees within that product sold in the small or large group market in one or more states, or a self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more states. Under this revised definition, in the third option listed above for a state to change its benchmark plan, the state will be able to look for a single employer plan anywhere in the country with a narrow set of benefits and use that. This will again mean states can cherry pick amongst products in order to design a benchmark plan of minimal coverage standards.

Lastly, it is important to remember that while the ACA's current EHB requirements and the above proposed provisions apply only to individual and small group plans within and outside the Exchanges, the ACA's ban on annual and lifetime limits and the annual cap on out-of-pocket costs of large employer plans are based on the EHB definition, so such plans will *also* be negatively impacted.

Even if the emergency services category of the essential health benefits remains untouched when a state chooses to change the benefits included within its benchmark plan EHB categories, the impact on emergency departments (EDs) across the country will still be significant. EDs already represent the safety net for millions of Americans and provide care to them without regard to ability to pay, as mandated by the Emergency Medical Treatment and Labor Act (EMTALA). A growing number of consumers already have coverage through a high-deductible health plan. As a result, they tend to defer seeking more routine care or visiting a primary care physician or specialist for more minor conditions or symptoms, since they will need to pay for the visit entirely out-of-pocket if they have not yet reached their deductible. Such deferral or delay will often result in their condition or symptoms becoming exacerbated, and eventually result in an unavoidable trip to the emergency department. At this point, due to the progression of their condition, their care in the ED will be much costlier and more complex than if they'd had earlier access to more routine care in a physician's office.

If finalized, the drastic proposed changes to the EHBs and requirements for state benchmark plans will significantly exacerbate this growing problem, and lead to a crisis point in emergency departments across the country. ***ACEP therefore opposes these proposed changes, and strongly urges HHS not to finalize them.***

Qualified Health Plan (QHP) Minimum Certification Standards

Network Adequacy

We are also concerned that the proposed rule would extend new guidelines on network adequacy that were finalized in the 2018 Market Stabilization rule. ACEP shared its concerns with the agency at that time on the impact it would have on network adequacy, and we are therefore disappointed these have been extended in this 2019 NBPP proposed rule.

The network adequacy requirements of many states are insufficient to address the needs of patients. This problem is longstanding, and only continues to grow as payers try to cut costs by further narrowing the size of their networks of various specialists – resulting in more enrollees lacking access, and the result is that they must seek care in emergency departments. Previously, CMS had set a minimum federal standard for network adequacy, and the 2018 Market Stabilization rule temporarily removed that requirement. The 2019 NBPP rule is now proposing to make permanent for 2019 and beyond this removal of a federal minimum, and will instead allow states full control over network adequacy.

It has been well-documented that states do not have good track records of overseeing Medicaid managed care organizations' (MCOs) network adequacy. Therefore, expanding their state responsibilities further makes no sense. As CMS acknowledged, the Inspector General's (IG) Evaluation Report of September 2014 (OEI-02-11-00320) found that enrollee access to providers varied widely from state to state and recommended improved oversight of state standards and methods to assess plan compliance, and that CMS work with states to identify and address access standard violations. In a subsequent OIG Report from December 2014 (OEI-02-13-00670), staff made calls to a sample of primary care providers and specialists and found that 35 percent could not be found at the location listed by the plan. The IG noted that CMS concurred with most of its recommendations.

If states do not regulate their network adequacy, the NBPP proposed rule allows for CMS to rely on certification through accreditation instead. Meeting accreditation standards is not the same as having a program and track record for governmental oversight and should not be substituted for it. Accreditation network adequacy standards are not publicly available, and, they are process and procedurally oriented rather than quantitative in nature. Further, accreditation organizations cannot resolve consumer grievances and cannot take action against an insurer with an inadequate network, other than to downgrade or remove accreditation. ***We urge CMS to maintain responsibility for establishing and enforcing network adequacy standards at the federal level and to not defer this activity to states and/or private accrediting organizations.***

Emergency physicians remain caught in the middle of two laws–EMTALA, that guarantees access to emergency medical care for everyone, and the ACA, that includes emergency services as an essential health benefit that QHPs must cover. Both have had the effect of increasing volume while discouraging incentives for health plans to enter into fair and reasonable contracts with emergency physicians to provide services at *reasonable in-network* rates. Accordingly, CMS' network adequacy proposals will only exacerbate what has been deemed an epidemic of “surprise billing” because it does not address the underlying problem: the majority of emergency physicians would prefer to practice in-network, but insurers have not negotiated in good faith. For the past five years, ACEP urged CMS' Center for Consumer Information and Insurance Oversight (CCIIO) to require insurers to use an

objective, transparent national database like *FairHealth* to establish reasonable out of network rates and therefore prevent patients from being left to pay the significant difference. ***We strongly urge CMS to adopt our recommended changes to the a “greatest of three” (GOT) methodology for determining payment for out-of-network emergency services, as laid out in ACEP’s most recent letter to CCIIO sent on October 19, 2017.***

Enforcement of the Prudent Layperson Standard

The Prudent Layperson Standard (PLP) provides that it is appropriate to seek care in the emergency department when there is a “medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part”. The PLP grew out of the insurance environment of the early 1980s, when private insurers routinely would require prior authorization for emergency department visits or deny payments for visits that they deemed inappropriate for that care setting, often based on a retrospective review or discharge diagnosis. If an individual wanted insurance to cover an emergency treatment, the patient was expected to contact his or her insurer for approval prior to the emergency department visit. If an individual sought care in the ED and his or her insurer later deemed that the visit was not a medical emergency – based on the final diagnosis, not the presenting symptoms – then the insurer would refuse to pay for the visit.

In response to such potentially dangerous and unfair requirements, many states enacted PLP laws that supported a patient's right to seek care in the ED. The federal Balanced Budget Act (BBA) of 1997 extended the PLP to Medicare and to Medicaid managed care plans. The Affordable Care Act then extended the standard in 2010 to health insurance plans in the group and individual markets.

Recently, private insurers (including QHPs) have begun once again to curtail patient access to emergency department care in violation of the PLP. Anthem plans in Missouri, Kentucky, and Georgia (and beginning in January 2018 also in Ohio, New Hampshire, and Indiana) have started to retroactively deny coverage for emergency visit based on the final diagnosis, not the presenting symptoms. This includes the QHP products Anthem has in any of these states. As a result of the policy, one patient in Kentucky was [recently denied coverage for her ED visit](#) for what turned out to be a ruptured ovarian cyst—a condition that while in and of itself is not immediately life-threatening, shares the same symptom (severe abdominal pain) as a number of conditions which are threatening to life (ruptured ectopic pregnancy, appendicitis, etc.). This was a direct violation of the PLP.

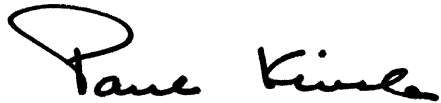
Centene, another insurer with QHP plans in multiple states, has begun to “downcode” to a level 3 reimbursement any level 4 (99284) or level 5 (99285) emergency room service billed to the insurer that it deems has “a diagnosis indicating a lower level of complexity or severity” as determined by “a coding algorithm strategy to automatically adjudicate emergency department claims based on the applicable ED claim category in accordance with the diagnosis code appearing on the claim.” Again, this is a direct violation of the PLP since Centene is making the determination automatically using a diagnosis code. Patients don’t come to the emergency room with a known diagnosis, only symptoms—it is illegal to deny or reduce coverage based on the diagnosis. CMS has previously itself stated as such, most recently in the [2016 Medicaid Managed Care Final Rule](#), saying of the PLP:

“Regarding the PLP requirements of the BBA of 1997 and the use of approved lists of emergency diagnosis codes, we remind commenters that consistent with our discussion in the 2002 managed care final rule at 67 FR 41028-41031, we prohibit the use of codes (either symptoms or final diagnosis) for denying claims because we believe there is no way a list can capture every scenario that could indicate an emergency medical condition under the BBA provisions...While this standard encompasses clinical emergencies, it also clearly requires managed care plans and states to base coverage decisions for emergency services on the apparent severity of the symptoms at the time of presentation, and to cover examinations when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson...The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens.”

We therefore call on CMS to reiterate the Prudent Layperson Standard in the Final NBPP, and affirm with language similar to the above how it applies to coverage of emergency department visits by QHPs, as required by the ACA.

We appreciate the opportunity to share our comments and continue to look forward to continuing working with you and your staff. If you have any questions, please contact Laura Wooster, ACEP's Associate Executive Director of Public Affairs at lwooster@acep.org.

Sincerely,

A handwritten signature in black ink that reads "Paul Kivela". The signature is fluid and cursive, with the first name "Paul" and last name "Kivela" clearly distinguishable.

Paul D. Kivela, MD, MBA, FACEP
ACEP President