December 22, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS 9944-P

Dear Administrator Tavenner:

On behalf of the American College of Emergency Physician's 33,000 members 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 are pleased to have the opportunity to comment on aspects of the Notice of Benefit and Payment Parameters for 2016 draft regulation for health plans and insurers. This proposed rule provides new information and/or clarifications on numerous issues and requirements relating to qualified health plan operations under the exchanges, ranging from coverage eligibility to risk adjustment models to reinsurance. Our comments relate specifically to cost sharing.

The Centers for Medicare & Medicaid Services (CMS) proposes to make a technical correction to 156.130 (c) which would allow plans the option of counting cost sharing amounts spent for out-of-network services toward an enrollee's annual cost sharing limit. We must question how many plans would agree to forgo maximum cost sharing since it would not be in their financial best interest, and instead reiterate our long standing proposal that CMS incorporate language that would require plans to pay out-of-network emergency services at verifiable market rates that would reduce or mitigate balance billing and reduce enrollee out-of-pocket costs under the "greatest of three" payment options from the interim final (IF) rule of June 28, 2010. (OCIIO-9994-IFC)

The IF rule stated that a health plan should be required to pay a "reasonable amount" to a physician or other provider of emergency services before a patient becomes responsible for paying that health care provider the difference between the provider's billed charge and the amount the health plan has paid. This reasonable amount should reflect the local commercial value of these services, less applicable co-insurance payments and deductibles. "CMS recognized the importance of reasonable reimbursement by stating that these patient protections would be defeated if the plans paid 'an unreasonably low amount to a provider'." Instead, we have documented and shared with leadership of CMS' Center for Consumer Information and Insurance Oversight (CCIIO) that many payers have significantly reduced payment for the same emergency service evaluation and management (E/M) code between 2012 and 2013, resulting in increased enrollee financial liability.

We ask CMS once again to structure a requirement whereby insurers/plans reimburse emergency providers via a "usual and customary charges" (UCR) methodology (adjusted geographically) using a transparent UCR database that cannot be manipulated and is verifiable by providers and outside experts.

By requiring that health plans pay the lesser of the billed charge, or the 80th percentile of usual and customary charges for the emergency services provided, health plans will be protected against unreasonably high charges, and patients will be protected against unreasonably high personal financial liability for emergency services received from non-contracted providers.

ACEP and EDPMA are committed to working closely with CMS to ensure enrollee protections and appropriate coding, billing, and payment of physician services. Should you have any questions regarding our comments, please contact Barbara Tomar, ACEP's Director of Federal Affairs, at btomar@acep.org or Elizabeth Mundinger, Executive Director, EDPMA at emundinger@edpma.org

Sincerely,

Michael J. Gerardi, MD, FACEP
President, ACEP

Sincerely,

James A. Kolka, D.O., FACEP
Chair, EDPMA Board of Directors