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**Docket:** IRS-2010-0015

Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection and Affordable Care Act

**Comment On:** IRS-2010-0015-0001

Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection and Affordable Care Act:

**Document:** IRS-2010-0015-0010

Comment on FR Doc # 2010-15277

## Submitter Information

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**Phone:** 415-378-9131**Organization:** None

## General Comment

Re: Comment on 45 CFR 147.138(b)(3)

## Suggested changes:

(1) As currently written, the proposed regulations could be construed to impose on plans an obligation to pay more than billed charges to emergency room professional and hospitals. "Or billed charges, if less" language should be added to these regulations --at end of section 147.138 (b)(3) -- to clarify this is not intended by these new regulations..

(2) The proposed regulations require a plan to pay at least what Medicare would pay for emergency charges. The Medicare payment number should be increased by a factor that adjusts for the payment rate over-and-above Medicare rates that commercial payers are reimbursing physicians or hospitals. This adjustment-factor can be readily determined (at no cost to a plan or DOL) as such an adjustment-factor is currently being annually calculated and reported by MedPAC.

(3) Additional consumer-protection safeguards should be added to minimize the balance billing obligations of consumers for the emergency services covered by these regulations.

(i) If a plan uses secondary PPO networks, negotiations, or other arrangements to reduce the

amount owed for out-of-network emergency services, any such reduction from billed out-of-network charges will first accrue to the benefit of reducing the consumer's balance billing obligation before the plan reduces its payment obligation;

(ii) a plan will provide beneficiaries with the data-points it uses to calculate its out-of-network payment obligation so that the beneficiary might use this data to negotiate a reduction in her/his balance billing obligation.

(iii) (iii) If the balance billing obligation is for facility charges, hospitals will provide the beneficiary with an estimate of an amount that is "no more than the lowest amount charged to individuals who have insurance covering such care." (current data requirement for charity hospitals per Patient Protection and Affordable Care Act (Sec. 9007 (a)(5)(A))

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## Attachments

**IRS-2010-0015-0010.1:** Comment on FR Doc # 2010-15277

Vincent Drucker  
460 Summit Avenue, Mill Valley, CA 94941  
415-378-9131 jvdrucker@yahoo.com

Re: Comment on 45 CFR 147.138(b)(3) -- (Patient Protection Regulations pertaining to requiring non-grandfathered plans to reimburse appropriately for out-of-network emergency charges)

Suggested changes:

- (1) As currently written, the proposed regulations could be construed to impose on plans an obligation to pay more than billed charges to emergency room professional and hospitals. "Or billed charges, if less" language should be added to these regulations --at end of section 147.138(b)(3) -- to clarify this is not intended by these new regulations..
- (2) The proposed regulations require a plan to pay at least what Medicare would pay for emergency charges. The Medicare payment number should be increased by a factor that adjusts for the payment rate over-and-above Medicare rates that commercial payers are reimbursing physicians or hospitals. This adjustment-factor can be readily determined (at no cost to a plan or DOL) as such an adjustment-factor is currently being annually calculated and reported by MedPAC.
- (3) Additional consumer-protection safeguards should be added to minimize the balance billing obligations of consumers for the emergency services covered by these regulations.
  - (i) If a plan uses secondary PPO networks, negotiations, or other arrangements to reduce the amount owed for out-of-network emergency services, any such reduction from billed out-of-network charges will first accrue to the benefit of reducing the consumer's balance billing obligation before the plan reduces its payment obligation;
  - (ii) a plan will provide beneficiaries with the data-points it uses to calculate it's out-of-network payment obligation so that the beneficiary might use this data to negotiate a reduction in her/his balance billing obligation.
  - (iii) If the balance billing obligation is for facility charges, hospitals will provide the beneficiary with an estimate of an amount that is "no more than the lowest amount charged to individuals who have insurance covering such care." (current data requirement for charity hospitals pursuant to Patient Protection and Affordable Care Act(Sec. 9007 (a)(5)(A)

### **Further Discussion Of The Suggested Changes**

**(1) "Or billed charges, if less" language should be added to these regulations --at end of section 147.138(b)(3) -- to clarify the intention of these new regulations.**

Sometimes billed charges will be less than the payment amounts calculated pursuant to these regulations. Although the examples in the proposed regulations do not show this occurring, it is most likely to be the case when payments are based on UCR data.

The UCR rates used in Example 4 (page 37421, Federal Register, Vol. 75, No 123, Monday June 28, 2010) are, in my professional opinion,<sup>1</sup> significantly understated.

- UCR rates for professional fees for emergency services are around 300% (3 times) what Medicare pays in many geographic areas (as such areas are defined by Medicare for purposes of its payment calculations).
- The median mark-up over costs of hospital's emergency services is about 300% according to the most current Medicare cost report data submitted by hospitals for most geographic areas. The number is around 420% for the 80<sup>th</sup> percentile of emergency charges – and maybe skewed even higher as UCR rates for hospital outpatient services are difficult to calculate in a way that is actuarially valid.<sup>2</sup>

**(2) Paying physician over-and-above what Medicare pays by a calculated percentage and paying hospitals over-and-above what Medicare pays by a calculated percentage.**

MedPAC annually calculates the percentage over-and-above what Medicare pays that commercial payers are paying physicians and hospitals. These factors are annually reported in MedPAC's Annual Report to The Congress and/or MedPAC's mid-year Data Book. Using such an adjustment factor is consistent with the requirements of the Patient Protection and Affordable Care Act (Sec 2719A(b)(C)(II) that "if such (emergency) services are provided out-of-network, the cost-sharing requirements (expressed as copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network."

This requirement is, I believe, necessary inasmuch as the language in the proposed regulation -- 147.138(b)(3)(A) – allows payers an easily way to opt-out of having to use their median in-network payments for comparable emergency services as a basis for determining their out-of-network payment obligation. A plan can easily negotiate only bundled payment rates for their in-network emergency services. Under the proposed regulatory language in 147.138(b)(3)(A), this will automatically exempt the plan from having to include, in its calculation of its payment obligation, the median per-service amount it is paying to in-network providers for the same emergency services.

**(3 i) Having a plan's reduction in the total payment obligations for an on out-of-network emergency service accrue first to reduce any balance billing obligation of the patient before the plan reduces its payment obligation.**

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<sup>1</sup> For more than 20 years I was professionally involved with physicians' ER billings, facilities' ER billings, and payers' reimbursement for ER services. This included:

- CEO of a company that billed and collected for hospital-based providers, mainly ER physicians.
- Co-founder and senior executive of a number of firms (including TRIM – predecessor of Quadramed- and Healthcare Plus Financial Management) that worked for hospitals nationally in areas that included ER documentation, ER cost-accounting, ER charge-setting and billing practices.
- Co-founder and CEO of a company (FairPay Solutions) that provided data for payers to use to determine their facility payment obligations pursuant to states' workers' compensation statutes and regulations.

<sup>2</sup> This is evidenced by the gyrations Medicare goes through each year to simply calculate the median national hospital outpatient charges for each hospital outpatient service. Medicare annually calculates the median charge for each service included in each APC hospital outpatient payment group. This is a legal requirement to assure that each APC payment group does not include hospital services for which the median national hospital charge is either too-high or too-low for the service to be included in the specified APC payment group. Medicare's annual report on its median calculations by APC and CPT shows that less than 5% of the total hospital outpatient bills Medicare processes meet its stringent requirements for valid data that can, according to its actuaries, be included in this annual analysis.

It has been extensively documented, by both providers and in several court cases (involving Humana and United HealthCare in Utah) how plans use a variety of tactics (e.g. secondary “leased” networks, negotiations, etc.) to reduce the amount owed for out-of-network services. The Humana case shows, to their credit, that they had been using a secondary PPO network to reduce the balance billing payment obligation of the patient. In the United case in Utah the court ruled that United could use tactics to solely reduce the out-of-network payment it owes -- and stick patients with the maximum balance billing obligation -- unless the plan documents specified otherwise.

I am proposing that additional consumer-protection language be added to the regulations to address this. The language would be along the following lines:

“If a plan uses tactics that reduce the payment owed (by plan and beneficiary) for emergency services covered by these regulations, any savings from billed charges will first accrue to the benefit of reducing the patient’s balance billing obligation.”

#### New Example 7:

Same facts as example 5, except plan uses a secondary PPO network to reduce by 20% the total amount owed from \$125 to \$100. This costs the plan 10% of the \$25 savings (\$2.50) as a “licensing fee” to the secondary PPO network.

Conclusion: The plan is responsible for paying \$92.80, 80% of \$116. The beneficiary is responsible for paying \$10.70, the sum of \$100-92.80 plus \$2.50.

#### New Example 8

Same facts as example 5, except plan uses negotiations to reduce by 40% the total amount owed from \$125 to \$75. This costs the plan 10% of the \$50 savings (\$5.00) as a “fee paid gto a 3<sup>rd</sup> party negotiations firm.

Conclusion: The total amount owed is \$75. The plan is responsible for paying \$75 to the provider of the covered emergency services and \$5.00 as its costs of obtaining the discounted out-of-network savings, since the total amount it pays is less than the \$92.50 it would otherwise have been obligated to pay. The beneficiary pays nothing.

#### New Example 9

Same facts as Example 8

**Conclusion: The total amount owed is \$75. But the plan only pays \$42.80 to the provider (\$92.80 which is 80% of the \$116 it is calculated it owes MINUS the \$50.00 reduction from total billed charges it obtains by using the discount of a secondary network. The beneficiary is obligated to pay \$58.20(\$150-\$92.80).**

**This would not be allowed under the revision I propose. But absent language in the regulations that addresses this, this will continue to be extensively done by plans to the detriment of consumers.**

**(3 ii) Having a plan obligated to provide beneficiaries with the data points it used to calculate it’s payment obligation for emergency services covered by these regulations.**

This will provide a beneficiary with data s/he will find useful to negotiate a reduction in her/his balance billing obligation. Such a requirement would not be burdensome to a plan inasmuch as (a) the plan will have already calculated relevant data points in order to appropriately pay for emergency services covered by these regulations; and (b) these data points can be readily added to the explanation-of--benefits a plan currently provides to a beneficiary.

**(3 iii) If the balance bill owed is for facility charges, hospitals will provide beneficiary with an estimate of an amount that is “no more than the lowest amount charged to individuals who have insurance covering such care.”**

For emergency services, the balance owed will be greatest for a facility's bill. The sums balanced-billed by a hospital facilities for its emergency services are likely to be 4-10 times more than the balances-billed by ER doctors.

Adding this requirement to these regulations will give a beneficiary another data point from which s/he can negotiate a reduction in her/his balance billing obligation for the hospital emergency services covered by these regulations. .

This proposed consumer protection requirement will not impose any burden on non-propriety hospitals as they are already being required, pursuant to Patient Protection and Affordable Care Act(Sec. 9007 (a)(5)(A), to provide this calculation to indigent patients.

I do not believe such a requirement will be burdensome for proprietary hospitals as they already have (either in-house or via a contracted “revenue cycle management” firm) sophisticated systems for estimating this. The data in such systems today can easily provide this data-point at minimal cost to a proprietary hospital.

Please contact me if you require additional details on any of the points I have raised.

Respectfully submitted,

J. Vincent Drucker

**Disclosure of Potential Conflicts of Interest**

I have no current source of revenue from any of the suggestions submitted above, as I am retired. My spouse has no sources of revenue from any of the suggestions submitted above. My spouse and I have no contracts that would allow us to have, in the future, any revenues from any of the suggestions submitted above. I have no children under 18 years of age or partners that would have any revenues from any of the suggestions submitted above.