

January 29, 2020

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
PO Box 8010  
Baltimore, MD 21244-8010

CMS 9915-P

## Re: Transparency in Coverage Proposed Rule

Dear Administrator Verma:

On behalf of our 38,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to respond to a proposed rule from the Departments of Labor, Health and Human Services (HHS), and the Treasury (“the Departments”) that aims to enhance transparency in coverage by requiring most health insurance plans to provide consumers with information that will help them understand their out-of-pocket costs before receiving a service. Overall, ACEP supports the Trump Administration’s commitment to improving price transparency. However, we believe that it is extremely important that the Departments keep in mind issues that are unique to emergency care if they decide to finalize any of the proposals in the rule.

On June 24, 2019, President Trump issued the “Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First” that highlighted specific actions his Administration should take to address this issue.<sup>1</sup> The proposed rule carries out Section 3(b) of the Executive Order. Specifically, the Departments propose the following two new requirements for group health plans (including self-insured group health plans) and health insurance issuers in the individual and group markets:

1. ***Give consumers real-time information about out-of-pocket costs:*** Provide consumers with personalized out-of-pocket cost information for all covered health care items and services through an internet-based self-service tool and in paper form upon request.
2. ***Disclose on a public website their negotiated rates for in-network providers and allowed amounts paid for out-of-network providers:*** Make available to the public, including stakeholders such as consumers, researchers, employers, and third-party developers the in-network negotiated rates with their network providers and historical payments of allowed amounts to out-of-network (OON) providers through standardized, regularly updated machine-readable files.

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<sup>1</sup> The Executive Order is available at: <https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/>.

ACEP believes that the first proposal can benefit consumers, as we strongly feel that it is the health plan's responsibility to clearly provide information to consumers about the potential costs of seeking non-emergency care under their particular coverage before they receive any services. Patients today truly do not understand their "high deductible" health plans and there is a dearth of information on "co-insurance," "deductibles," and "co-pays." Many so-called "surprise bills" actually result when patients receive a covered service but were unaware that they would be required to pay the whole cost out-of-pocket because they have a large deductible that has not been met. OON deductibles continue to grow higher, particularly in the individual market where the median OON deductible is approximately \$12,000. In about 30 percent of individual market plans with OON coverage, the deductible is greater than \$20,000.<sup>2</sup> While physicians and other health care practitioners can participate by helping patients interpret their cost-sharing requirements, only the insurer knows exactly what the requirements are for that patient's particular coverage type and product, as well as how far along the patient is in meeting their deductible. Therefore, the onus must be on insurers to make these costs transparent to patients. If consumers have real-time information about their cost-sharing obligations from their health plans, as this rule proposes, they can make more informed decisions about receiving non-emergency services.

However, we do have concerns with the second proposal related to sharing negotiated rates for in-network providers and allowed amounts paid for out-of-network providers. Although we believe patients deserve meaningful information about the price of their healthcare services, doing so in this manner could be unnecessarily burdensome, detract from the relevant patient cost-sharing information, and have unintended effects on the market as providers and payors are pressured to negotiate basic fee schedules. The requirement to disclose rates could lead to anticompetitive behavior once payors and providers are aware of the rates that their competitors have negotiated. Numerous legal complications will likely arise from private payors attempting to meet the requirements to disclose the rates they have privately negotiated with their network providers. For example, many current provider-payor contracts include non-disclosure agreements regarding these negotiated rates, and the Departments do not fully address these and other such factors in the rule.

We also have some additional comments on the rule, the details of which are found below. First, we specifically recommend that the Departments create a clear distinction between emergency and non-emergency care by finalizing separate requirements for both. Next, we respond to two requests for information in the rule: 1) whether group health plans and health insurance issuers should also be required to make the cost-sharing information available through a standards-based application programming interface (API); and 2) how health care quality information can be incorporated into the price transparency proposals. Finally, we have some comments on HHS' proposal to allow health plans to take credit for shared savings payments in their medical loss ratio (MLR) calculations.

### ***Emergency vs. Non-Emergency Care***

ACEP is concerned that the rule does not discuss how the proposed requirements may be applicable in emergency situations and what health plans' obligations should be to help consumers understand potential costs of emergency treatment. While we believe the first proposal may be beneficial to patients who have time to shop for services and schedule a visit or procedure, we urge the Departments to adjust their requirements for acute unscheduled emergency

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<sup>2</sup> Hempstead, K. "Percent of Plans with Out-of-Network Benefits: To Infinity and Beyond: Exposure to Out-of-Network Bills Is High and Rising in the Individual and Small Group Markets"; Robert Wood Johnson Foundation Marketplace Pulse. October 4, 2018. <https://www.rwjf.org/en/library/research/2018/10/percent-of-plans-with-out-of-network-benefits.html>.

care. During emergencies, a patient's concern should be focused on receiving appropriate care, rather than choosing their emergency care based on cost. In the emergency department (ED), minutes and seconds matter and emergency physicians are often required to exercise their best clinical judgement quickly. Patients who have life-threatening illnesses and injuries obviously do not have the ability to shop around for the "lowest cost" provider.

As emergency physicians, we are subject to the Emergency Medical Treatment and Labor Act (EMTALA), which guarantees that we provide patients with emergency medical care regardless of their insurance status or ability to pay. ACEP strongly supports the patient protections embedded within the EMTALA requirements. EMTALA stipulates that a hospital may not place any signs in the ED regarding the prepayment of fees or payment of co-pays and deductibles which can have the chilling effect of dissuading patients from "coming to the emergency department." To do so could lead patients to leave prior to receiving a medical screening examination and stabilizing treatment without regard to financial means or insurance status, which is a fundamental condition for satisfying EMTALA, and one of the most foundational principles of an important patient protection that was enacted three decades ago. If we attempt to get pricing information to patients prior to stabilizing them, not only would that be an EMTALA violation, but it could also potentially cause the patient's health to deteriorate since it could delay the patient from receiving critical care. While the penalties for violating EMTALA are steep, our bigger concern is that if transparency for emergency care is not approached carefully, we could inadvertently be putting our patients in a position of making life-or-death health care decisions based on costs.

Furthermore, in delivering acute care, knowing what patients' total out-of-pocket costs will be before they are diagnosed and stabilized is nearly impossible until a proper course of medical care and progression is followed. A large proportion of emergency care involves the acute diagnosis, treatment, and stabilization of diffuse and undifferentiated clinical conditions. For example, two of the most common patient presentations are "chest pain" and "abdominal pain." These initial symptoms have a large range of ultimate diagnoses and require a large variety of patient-specific lab tests, radiology exams, and other interventions. In many cases, emergency physicians only decide to order a particular test once they have seen the result of another test already performed. This is very different from being able to figure out total costs for an urgent care patient with a small, clean, superficial laceration or a sore throat. Further complicating the issue is the fact that emergency care is billed in two separate components, the facility fee and the professional fee. Therefore, patients must sort through costs included in at least two different bills, each of which may have different cost-sharing obligations associated with it (not to mention additional potential bills from other specialists who might be involved in an emergency encounter, such as a radiologist and an orthopedist in the case of a fractured limb).

We believe that the best time for health plans to inform consumers about the potential costs of emergency care is **when consumers obtain their coverage**—before an emergency occurs. Patients should know which clinicians and hospitals in their area are in-network and fully understand their cost-sharing obligations for emergency care, including any in-network and out-of-network deductible amounts and out-of-pocket caps. Further, provider directories should be up-to-date, and all insurers should meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties.

While the Departments do acknowledge that it may not be appropriate for consumers to look at publicly posted rates for in-network and out-of-network care for emergency situations, the Departments do not include any specific requirements for health plans to help patients better understand emergency care costs. **Therefore, if the Departments decides to finalize the proposals, we urge the Departments to include an additional requirement in the final rule for health plans to provide consumers with information they need to fully understand their cost-sharing obligations for emergency services at the time they obtain their coverage.**

**Health plans should also update this information on an annual basis or when major changes occur that would impact their access to and overall cost of emergency care, such as changes to their provider network.** One specific requirement the Departments should consider for health plans is requiring them to include the in-network and out-of-network deductible amounts on each consumer's insurance card. This information will serve as an effective reminder for policyholders each time they show it at the point of care what the limits of their insurance coverage really is, and the amounts of cost-sharing they will be personally liable for should they require emergency care. For non-emergency care, this information can greatly facilitate providers being able to assist patients at the point of care with navigating their coverage and benefits and more specifically provide out-of-pocket pricing estimates. Finally, for both emergency and non-emergency care, having this information recorded in a patient's record can help the provider resolve billing and cost-sharing issues and potential disputes on the patient's behalf, keeping the patient fully out of the middle.

We also request that the Departments add a requirement that health plans or issuers must provide their enrollees with meaningful and simple explanations regarding coverage for emergency care that they are guaranteed under federal law. This includes informing them of the prudent layperson standard, which states that payors must cover any medical condition, "manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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: 1) placing the health of the individual (or a pregnant woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part."<sup>3</sup> While this requirement is already in federal law for all commercial plan types, over the past few years, insurers such as Anthem, United, and Blue Cross Blue Shield of Texas, have all implemented policies that to varying degrees can retroactively deny a range of emergency care for policyholders who seek it for symptoms that turn out to be non-emergent.

Lastly, we request that the Departments highlight the differences between emergency care and non-emergency care and clearly explain that the currently proposed requirements are only applicable during non-emergency situations.

### ***Request for Information on Disclosure of Pricing Information through a Standards-based API***

The Departments are considering whether to require, through future rulemaking, group health plans and health insurance issuers to make price information available through a standards-based API. This concept builds off the data sharing proposals included in the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Proposed Rule<sup>4</sup> and the Office of the National Coordinator (ONC) for Health Information Technology Interoperability and Information Proposed Rule.<sup>5</sup> Specifically, in CMS' proposed rule, the agency proposes to require both public and private health plans including Medicare Advantage (MA) organizations, state Medicaid fee-for-service (FFS) and managed care programs and plans, CHIP FFS and managed care entities and plans, and qualified health plans (QHPs) in the federally facilitated exchanges (FFE), to leverage third-party application developers using HL7 FHIR and APIs to make claims and other health information available to patients. If this CMS proposal is finalized, the Departments are considering extending this requirement to include price information.

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<sup>3</sup> 42 Code of Federal Regulations (CFR) 438.114(a).

<sup>4</sup> Medicare and Medicaid Programs: Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-facilitated Exchanges and Health Care Providers Proposed Rule, 84 Fed. Reg. (March 4, 2019).

<sup>5</sup> 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program Proposed Rule, 84 Fed. Reg. (March 4, 2019).

As expressed in our comments on the CMS proposed rule,<sup>6</sup> one of our major concerns with making such information available to consumers is how that data (which can be extended to include price information) is protected and secured. We recognize that we are entering into a whole new world in terms of data sharing and consumer access to their healthcare information and that it is even more essential now to protect that information after the initial encounter. As the ways in which information can be exchanged continue to grow, we believe that privacy and security laws need to be updated and extended to cover all possible types of data-sharing. That is why we were surprised that no changes to HIPAA were proposed in CMS' rule, even though the Office of Civil Rights specifically asked what modifications were needed to support efforts to prohibit information blocking in a Request for Information.<sup>7</sup> As CMS notes in its rule, health plans must follow the current rules and regulations under HIPAA up until third-party applications retrieve the data from the open APIs, at which point they no longer have to take on any responsibility once third-party applications get ahold of the data. Many of these third-party applications are not covered entities regulated under HIPAA, and so are instead regulated by the Federal Trade Commission (FTC), which has the authority to investigate and take action against unfair or deceptive trade practices.

As more and more third-party applications obtain data from open APIs, we need to think extremely carefully about how to ensure patient's information is protected and that these third-parties do not engage in any deceptive practices that could potentially jeopardize the privacy and security of the data. ACEP agrees with the Departments that disclosing pricing information can violate privacy if not protected appropriately. The example provided in the proposed rule of a pregnant woman requesting cost-sharing information with in-network obstetricians is extremely on point. If third-parties get ahold of that data request and pricing information, that woman's sensitive health status is now exposed. Third-party applications typically use data for a variety of purposes, and we think it will be extremely difficult for patients to truly understand what aspects of their information are being shared and with whom. In fact, some studies suggest that current applications, like Facebook and Google, already share health-related information without the individual's knowledge or informed consent.<sup>8</sup> As the health IT applications ecosystem continues to evolve, patients need to be provided clear guidance and information about what they agree to when signing into an application, and informed that their personal information could be at risk. Therefore, we encourage the FTC to put out strong guidance or regulations clearly articulating what are and are not acceptable uses of the data, using HIPAA privacy and security rules as a guiding benchmark. The Departments should also commit to working with the FTC on that additional guidance.

If the Departments are to propose any such requirement in future rulemaking, we also encourage them to do as much as possible to ensure that consumers are protected and that they truly understand how their data are being used. They should consider requiring health plans to create an easy-to-understand questionnaire that they would require third-party applications to fill out in order to have access to the data on the open API. This questionnaire would include basic questions about how the third-party application plans to use the data. Consumers should then have access to the answers on this questionnaire before using the third-party application. That way, even if the third-party application has a data use agreement that they require consumers to agree to, there will be another mandatory safeguard in place

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<sup>6</sup> ACEP's comments on CMS' Interoperability and Patient Access Proposed Rule are available here: <https://www.acep.org/globalassets/sites/acep/media/advocacy/federal-advocacy-pdfs/acep-response-to-cms-interoperability-and-patient-access-proposed-rule.pdf>.

<sup>7</sup> Request for Information on Modifying HIPAA Rules to Improve Coordinated Care, 83 Fed. Reg. 64305 (December 14, 2018).

<sup>8</sup> Huckvale K, Torous J, Larsen ME, Assessment of the Data Sharing and Privacy Practices of Smartphone Apps for Depression and Smoking Cessation, JAMA Netw Open. 2019;2(4):e192542. doi:10.1001/jamanetworkopen.2019.2542.

to ensure that consumers understand all the potential uses of their data once that third-party application retrieves all of it from the open API.

### ***Request for Information on Provider Quality Measurement and Reporting in the Private Health Insurance Market***

The Departments are interested in how public and private sector quality measures might be used to compliment cost-sharing information for plans and issuers in the private health insurance market. They seek comment on a range of questions around whether they should also impose requirements for the disclosure of quality information for providers of health care services. Overall, ACEP supports the concept of providing quality-related information to consumers in a standardized format. However, we caution against the use of quality measures that have not been thoroughly tested or validated as they may lead to unintended changes in physician practice patterns and negative patient outcomes. We support the use of evidence-based and externally-validated quality measures that focus on positively impacting patient-centered outcomes. Without this standard, we would be concerned that the measures tracked would simply add to administrative burden and not truly help improve patient care.

One specific question the Departments raise is whether it is feasible to use health care quality information from existing CMS quality reporting programs, such as the Medicare Quality Payment Program (QPP) in the individual and group markets. We have existing general concerns with how CMS currently displays performance-related information in the QPP. Individual and group performance on the QPP is displayed on Physician Compare. However, a physician's rating on Physician Compare does not always directly correlate to their score in the Merit-based Incentive Payment System (MIPS) track of the QPP. Further, Physician Compare publicly reports all quality measures reported in MIPS, providing the incentive for clinicians to "cherry-pick" the six quality measures that they would perform the best on. We believe this policy leads to a less accurate depiction of a clinician or group's overall quality performance and disincentivizes clinicians to report on as many potentially unfavorable measures as possible in an attempt to improve overall quality and patient safety. Beyond Physician Compare, we also have concerns about the ability for patient experience and satisfaction measures to measure performance that is actually attributable to an individual clinician.

We believe these existing concerns about accurate quality measurement and public reporting must be addressed before the Departments introduce any new requirements that would compel health plans to share quality information on their in-network providers with patients. Providing incorrect or incomplete quality information to patients, especially during emergency encounters, could potentially cause patients to avoid or delay receiving vital services simply because they were misinformed.

Finally, we want to re-emphasize that EMTALA forbids emergency physicians from attempting to get pricing information to patients prior to stabilizing them since doing so could lead patients to leave prior to receiving a medical screening examination. If the Departments consider implementing a future policy to require quality data to be integrated with pricing information, they must consider how such a proposal would interact with this important EMTALA protection.

### **Overview of the Proposed Rule Regarding Issuer Use of Premium Revenue under the Medical Loss Ratio Program: Reporting and Rebate Requirements – The Department of Health and Human Services**

HHS is proposing to allow health plans that "empower and incentivize consumers through the introduction of new or different plans that include provisions encouraging consumers to shop for services from lower-cost, higher-value providers, and that share the resulting savings with consumers, to take credit for such 'shared savings' payments in

their medical loss ratio (MLR) calculations.”<sup>9</sup> In general, ACEP supports efforts by health plans to create innovative benefit designs that truly help our patients receive better care. However, we are concerned that the proposal is too general and allows health plans to take credit through their MLR calculation for any design change where the plan would share savings with enrollees who “shop for health care services and choose to obtain care from lower-cost, higher-value providers.” Under such a proposal, health plans have the flexibility to define “lower-cost, higher-value providers” however they want, even if their definitions are not based on any evidence or if their consumers’ selection of these “lower-cost, higher-value providers” do not actually lead to better health outcomes. Therefore, we believe that health plans should only be allowed to make adjustments to their MLR if there is demonstrable evidence, through evidence-based and externally-validated outcome measures, that the participating enrollees are actually receiving better care at reduced costs.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP’s Director of Regulatory Affairs at [jdavis@acep.org](mailto:jdavis@acep.org).

Sincerely,

A handwritten signature in black ink that reads "William P. Jaquis". The signature is written in a cursive, flowing style.

William P. Jaquis, MD, MSHQS, FACEP

ACEP President

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<sup>9</sup> Transparency in Coverage Proposed Rule, 84 Fed. Reg. 65489 (November 27, 2019).