THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 2 0 2018

The Honorable Benjamin L. Cardin
United States Senate
Washington, DC 20510

Dear Senator Cardin:

Thank you for your letter to Secretary Acosta and me regarding potential violations of the Prudent Layperson Standard. I am responding on behalf of both the Departments of Labor (DOL) and Health and Human Services (HHS). We appreciate hearing from you on this important issue, and are pleased to provide information responding to your questions below.

The Medicare Advantage (MA) program specifies requirements concerning the Prudent Layperson Standard in regulations, guidance, and operational documents. These policies are based on section 1852(d)(3) of the Act (42 U.S.C. § 1395w-22(d)(3)). HHS adopted a regulation to implement this provision for MA plans, at 42 C.F.R. § 422.113. In addition, HHS reiterates Prudent Layperson Standard requirements to MA plans in Chapter 4, 20.2, of the Medicare Managed Care Manual, which can be found at, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf.

HHS has issued two State Medicaid Director letters (in 1998 and 2000), and an informational bulletin (in 2014), on the coverage of emergency services in Medicaid managed care, as well as to provide guidance about the Prudent Layperson Standard. The guidance can be found at the following links:

https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd041800.pdf
https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD022098c.pdf
https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf

With respect to private health coverage guidance, section 2719A(b) of the Public Health Service Act (PHS Act) (42 U.S.C. § 300gg-19a), provides that if a group health plan or health insurance issuer provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency services for an emergency medical condition consistent with certain standards related to cost-sharing, prior authorization, and network status of a provider. The Patient Protection and Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (Code), to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. HHS, DOL, and the Department of the Treasury have promulgated a regulation at 45 CFR 147.138(b) to implement this provision. The statute and regulation both incorporate the Prudent Layperson Standard in the definition of an emergency medical condition. Parallel DOL and Treasury regulations are at 29 CFR 2590.715-2719A(b) and 26 CFR 54.9815-2719A(b) respectively.

Regarding the use of codes to flag claims, HHS understands that Anthem's policy does not apply to Medicare or Medicaid populations. With respect to insured coverage, State laws may address the use of CPT codes. Regardless of State law, the Departments agree that CPT codes should not be the only factor in determining whether a medical emergency condition occurred and that evaluation of compliance with section 2719A of the PHS Act is contingent on the facts and circumstances of individual cases.

For group health plans covered by ERISA, DOL has made enforcement of the Prudent Layperson Standard under PHS Act 2719A a nationwide initiative under Employee Benefits Security Administration's (EBSA) Program Operating Plan for FY2018. As part of this initiative, investigations focus on compliance through review of plan documents, policies, and procedures as well as claims data analysis. One focus of the initiative is to identify and enforce against plans and service providers who have denied claims based solely on a final diagnosis, without accounting for a participant's presenting symptoms, or by limiting coverage of emergency services to an impermissible timeframe after the onset of symptoms.

With respect to health insurance issuers in the individual, small group, and large group health insurance markets, States generally have primary enforcement authority over health insurance issuers, with HHS having secondary authority. If a State does not have enforcement authority or elects not to enforce the federal insurance standards, HHS will directly enforce the federal standards in the State or enter into a collaborative enforcement agreement with the State. While we cannot comment on any open investigations, HHS has been monitoring State action on this issue and will work with the States to ensure that appropriate action is taken if necessary.

While DOL cannot comment on the specifics of any open investigations, as an example of a closed investigation, DOL previously investigated MagnaCare Administrative Services, LLC (MagnaCare). That investigation resulted in a Consent Judgment against MagnaCare, a third party administrator in New York providing services for ERISA-covered plans. DOL determined, as part of its investigation, that MagnaCare utilized diagnosis codes as the basis of emergency service claim denials. DOL also determined that MagnaCare failed to disclose to participants their right to supply additional medical records – which were intended to allow MagnaCare to determine whether the Prudent Layperson Standard was satisfied – before the claims were denied.

Pursuant to the terms of the Consent Judgment, MagnaCare will align its policies and procedures with both the DOL claims regulation standards and the Prudent Layperson Standard in adjudicating emergency services claims. MagnaCare will also notify any plan client whose plan violated the applicable laws, advise that they speak to counsel, and work with new plan clients to ensure the set-up of compliant benefit grids to allow for the adjudication of claims in accordance with the law. Further, for emergency service claims improperly denied during the investigative period (January 1, 2011 through December 30, 2015), MagnaCare will notify the plan clients (both present and former), plan participants and providers that their emergency service claims may have been denied for lack of information and that they may resubmit claims for reprocessing. This notice to participants will also solicit information as to whether any participant was adversely affected by such items as debt collection or negative credit report notification. Finally, MagnaCare agreed to change its Explanation of Benefit notices to inform participants of their ability to submit additional medical records to support their claim adjudication in accordance with the Prudent Layperson Standard. The Complaint and the Consent Judgment are enclosed with this response.

Further, HHS is not aware of MA plans implementing policies in contracts that discourage patients from seeking emergency medical care in emergency departments. MA plan complaints from enrollees are reviewed in HHS's Complaints Tracking Module by a HHS employee and MA plans. All written material provided by MA plans to MA enrollees, such as the annual Evidence of Coverage, are carefully reviewed to ensure that if MA enrollees believe they are having a medical emergency, they should immediately seek care at the closest available emergency facility. These processes are intended to prevent MA plans from implementing such policies.

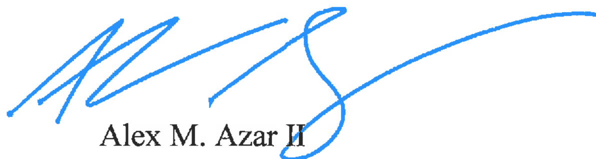
Regarding complaints received from State regulators about health insurer issuers offering group health coverage potentially violating the Prudent Layperson Standard, HHS has not had any direct contact with the State DOIs on this matter. However, we are continuing to monitor State actions. In addition, Section 506(a) of ERISA specifically instructs DOL to coordinate with other regulators (including State regulators) when such coordination would avoid unnecessary expense and duplication. DOL takes this instruction seriously and have entered into several Memoranda of Understanding with State regulators in order to facilitate the exchange of information. DOL was in contact with the NY Department of Financial Services and NY Department of Business and Insurance during the investigation of MagnaCare, to obtain and coordinate complaints relating to emergency services claims.

With respect to complaints about group health plans potentially violating the Prudent Layperson Standard, HHS has not received any such complaints. DOL receives investigative leads through complaints, news articles, targeted reviews of plan documents, and coordination with State regulators. An example of a complaint regarding a group health plan violating the Prudent Layperson Standard is explained in further detail above.

Finally, HHS has not received specific complaints about MA plans potentially violating the Prudent Layperson Standard. When a contracted provider furnishes a service or refers an enrollee for a service that an enrollee reasonably believes is a plan-covered service, the enrollee cannot be financially liable for more than the applicable cost-sharing for that service. For non-contracted provider claims, HHS conducts audits of MA plans to ensure proper payment of emergency post-service claims.

Thank you again for your letter. If you or your staff have questions, please feel free to contact the Assistant Secretary for Legislation at (202) 690-7627. I will share this response with the co-signer of your letter.

Sincerely,



Alex M. Azar II

Enclosure