American Hospital Association

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Jay Angoff
Director
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Department of Health and Human Services; Office of Consumer Information and Insurance Oversight; Docket No. OCIIO-9994-1FC; Interim Final Rule on Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; (Vol. 75, No. 123), June 28, 2010.

Dear Mr. Angoff:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the interim final rules implementing several elements of the insurance reforms contained in the *Patient Protection and Affordable Care Act* (ACA). Our comments specifically address the new patient protections that require health plans to establish equal enrollee cost sharing for emergency services delivered both in-network and out-of-network.

In an effort to protect enrollees from significant balance billing (which is allowed under the ACA) for out-of-network emergency services, the interim final rules include provisions setting minimum compensation rates to be paid by insurers to out-of-network providers for emergency services. That amount is the greatest of three possible amounts: (1) the median amount negotiated with in-network providers for the same services; (2) the amount calculated by the same method the plan generally uses to determine payment to out-of-network providers (such as the usual, customary and reasonable, or UCR, charge); or (3) the amount that would be paid by Medicare.

The AHA has significant concerns about the provision outlined in 45 CFR 147.138(b)(3)(i) and recommends that this provision be withdrawn for reconsideration. First, by setting a default rate, the Department of Health and Human Services (HHS) is engaging in rate setting without the apparent authority to do so. Second, the approach adopted will not protect enrollees as intended and will have several unintended consequences:

- Insurers will have no incentive to form adequate networks, thereby undermining the purpose of contracting to form networks.
- Providers will lose any limited leverage they may have to "vote with their feet" when confronted with an unfair contract, and participating provider rates will eventually drop even further.
- Insurers will be the primary beneficiary of the provision by limiting plan liability at an artificially low level.
- Consumers may be the biggest losers as they may be asked to close what will be a growing gap between the "default" payment rate and the emergency providers' expectations, leaving them vulnerable to even larger balance bills.

While we understand the logic behind the proposed rule and its intent to require that a reasonable amount be paid by insurers for emergency services before a patient becomes responsible for a balance billing requirement, recent history suggests that neither the concept of a default rate – the median in-network rate or the Medicare rate – nor the other proposed alternative – to pay out-of-network providers the UCR charge for emergency services – are viable options. The in-network rate and the Medicare rate are both highly discounted.

The problem with the other alternative – to use the same method the plan generally uses to determine payments for out-of-network services, generally UCR – is that no reliable database exists to calculate UCR. The only widely used database (owned by Ingenix, a wholly owned subsidiary of United HealthCare) has been under investigation and attack by law enforcement officials and in private litigation.

It has been a long-held belief in the provider community that the Ingenix database routinely undervalued UCR. It was therefore no surprise to providers that New York Attorney General Andrew Cuomo accused Ingenix of operating "a defective and manipulated database that most major health insurance companies use to set reimbursement rates for out-of-network medical expenses."

Mr. Cuomo's investigation quickly led to multiple multi-million dollar settlements with insurers who had relied upon the database. A portion of the settlement monies are now to be used to fund an independent not-for-profit database through FAIR Health, Inc., to properly and transparently calculate UCR. But this database does not yet exist. It is premature to finalize a rule that must rely on calculating UCR using a methodology that is, at a minimum, flawed.

The AHA recommends that you withdraw the provision in 45 CFR 147.138(b)(3)(i) for reconsideration of its unintended consequences. We agree that it is critical to address reasonable compensation for out-of-network providers who render emergency services for plan enrollees. However, we believe this provision, as written, will create a disincentive for insurers to engage in good faith negotiations with providers, resulting in unreasonable payments for emergency services rendered by out-of-network providers and large balance bills for consumers. As such, it may benefit only health plans, to the detriment of consumers and health care providers.

We thank you for the opportunity to comment. If you have any questions about our comments, please contact Ellen Pryga, AHA policy director, at epryga@aha.org or (202) 626-2267.

Sincerely

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