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August 27, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: OCIIO-9994-IFC, Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule

Dear Secretary Sebelius:

The Healthcare Association of New York State (HANYS), the only statewide hospital and continuing care association in New York State, representing more than 550 non-profit and public hospitals, nursing homes, home care agencies, and other health care organizations, submits this letter in response to the Department of Health and Human Services' (HHS) request for comments regarding *Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act (PPACA) Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule.*

HANYS' comments specifically address the patient protections outlined in the interim final regulations designed to establish a minimum level of compensation to be paid by insurers to non-participating providers for emergency services. The interim final regulations would require insurers to pay an amount equal to the greatest of three possible amounts: (1) the amount negotiated with in-network providers for the emergency service furnished (45 CFR 147.138(b)(3)(i)(A)); (2) the amount calculated by the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable (UCR) charge) (45 CFR 147.138(b)(3)(i)(B)); or (3) the amount that would be paid under Medicare for the emergency service (45 CFR 147.138(b)(3)(i)(C)).

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HANYS recognizes the importance of trying to find a method to help insurers determine a reasonable reimbursement rate for emergency services, but we have significant concerns that the provisions outlined in 45 CFR 147.138(b)(3)(i) will have the unintended consequences of creating a default rate, potentially and significantly undermining the purpose of contracting to form networks (and a primary reason that underpaid providers choose to leave networks), limiting plan liability at an artificially low level, and leaving consumers vulnerable to unexpectedly large balance bills.

The first and third alternatives set forth in the regulation would respectively require insurers to pay out-of-network providers either the same amount as that negotiated with in-network providers or the Medicare rate for the emergency service provided. Essentially both of these provisions would create a default rate, although it does not appear that the Patient Protection and Affordable Care Act grants HHS the statutory authority necessary to set such rates. Moreover, many health care providers argue persuasively that the very reason for leaving networks is dissatisfaction with the rates paid to participating providers.

If insurers are able to pay out-of-network providers a default rate, at least three undesirable things may result: insurers will have no incentive to form networks, providers will lose any limited leverage they may have to “vote with their feet” when confronted with an unfair contract and rates will be forced even lower for participating providers. Consumers, however, are potentially 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.

While we understand the logic behind the proposed rule and its intent to require that insurers pay a reasonable amount to health care providers for emergency services before patients are held responsible for the balance, recent history suggests that neither the concept of a default rate nor the other proposed alternative—to pay out-of-network providers the UCR rate for emergency services—is a viable option.

The second alternative set forth in the rule, to use the same method the plan generally uses to determine payments for out-of-network services, UCR, is disconcerting to us because no reliable database currently exists to calculate UCR rates. The only widely used database, Ingenix, is a wholly owned subsidiary of UnitedHealthCare, and has been under investigation and attack by law enforcement and involved in private litigations.

It has been a long held belief in the provider community that the Ingenix database routinely undervalued UCR rates. 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 numerous multi-million dollar settlements with insurers who had relied upon the database. A portion of the settlement monies are to be used to fund an independent not-for-profit database through FAIR Health, Inc., to properly and transparently calculate UCR rates. But this database does not yet exist. It is premature to finalize a rule that must rely on calculating UCR rates using a methodology that is flawed, at best.

While HANYS agrees that finding a methodology to determine reasonable compensation for non-participating providers rendering emergency services for plan members is important, given the concerns articulated herein, we prefer an approach that focuses on a "process," and not on default rates. In this regard, we have suggested to the regulators in New York that "baseball arbitration," or some similar method, is a more viable solution.

Therefore, we respectfully request that you abandon the provisions outlined in 45 CFR 147.138(b)(3)(i) so that non-participating providers are fairly compensated for furnishing emergency services. HANYS fears that the interim final regulations, as written, will disincentivize payers from engaging 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.

If you have questions about our comments, please contact Jeffrey Gold, Vice President, Managed Care and Special Counsel, at (518) 431-7730.

Sincerely,

Daniel Sisto
President

DS:jg

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