



Charles N. Kahn III
President and CEO

August 27, 2010

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

Re: Patient Protection and Affordable Care Act; 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 (*75 Fed.Reg.* 37,188 [June 28, 2010].)

Dear Mr. Angoff:

The Federation of American Hospitals (“FAH”) is the national representative of nearly 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, including inpatient rehabilitation, long-term acute care, cancer and psychiatric hospitals. We appreciate the opportunity to comment on the Department of Health & Human Services (“HHS”) rule 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 (“Rule”).

The FAH has long advocated on behalf of strong patient protections and commends the improvements to federal policy protecting those with preexisting medical conditions. Furthermore, many of the patients we see in our facilities each day are faced with lengthy and devastating illness. Addressing the existing annual and lifetime limits on the dollar amount of benefits, as well as prohibiting unfair rescissions of coverage for these insured individuals, is critical.

We also support the language of the Rule related to patient freedom of choice of health care professionals with respect to a plan or health insurance coverage with a network of providers. Patient choice of providers remains a priority for the FAH as we move forward with the implementation of several key provisions within PPACA.

“Essential Health Benefits”

In this, one of the first key rules of this historic legislation, the FAH asks that HHS give careful consideration to how this set of regulations will intersect with future PPACA regulations. We strongly urge HHS to consider defining an early and basic core set of benefits, such as inpatient and outpatient hospital coverage, to be included in the “essential health benefits” used for determining annual limits prior to 2014. “Essential health benefits” that apply to qualified health plans beginning in 2014 will be established by future regulations. While we appreciate the clear statement encouraging compliance with a “reasonable interpretation” of such benefits until that time, a temporary standard core set of benefits could provide needed clarity and provide protections for patients.

Emergency Services

The FAH supports the provisions related to Patient Protection and Affordable Care Act (“PPACA”) provisions on emergency services and many of HHS’s implementing policies in the Rule. FAH hospitals believe our patients are well served by (1) the universal use of a prudent layperson standard for patients seeking care furnished in emergency departments; (2) a ban on prior authorization for in-network and out-of-network emergency care or subsequent notice of an emergency department visit; and (3) the requirement for parity for out-of-network providers with in-network providers related to covered benefits and patient cost sharing for emergency services under the specific reimbursement payment requirements set forth in the in the Rule.

We appreciate that the Rule clearly acknowledges that it is detrimental to allow insurance products and carriers to pay for emergency services at levels as they see fit and seeks to establish appropriate objective benchmarks. Historically, insurance payment levels do not come close to covering the costs of providing emergency care, yet hospitals and emergency physicians must continue to provide services without regard to that shortfall due to the dictates of the EMTALA law. This is why an objective standard related to “fair payment” is very important.

We support the inclusion of a “greater of” test for determining the appropriate plan payment for out-of-network emergency services focusing on (1) median in-network rate; (2) usual and customary reasonable rate; and (3) the Medicare rate. We believe additional clarification is needed related to these concepts.

First, we believe that the Rule’s median in-network rate language needs more definition. Initially, this rate should be defined as the rate actually paid by the plans, inclusive of all payments made, without arbitrary excursions of self-defined “outliers” or “carve-outs.” Second, the median must be representative of the population to be measured, a true median or one that is appropriately weighted. This means that in the calculation to be made, network rates related to Medicare and Medicaid products should be excluded given they do not result from free-market

negotiation (and the Medicare rate is factored into this analysis in its own category). Should state regulatory authorities have discretion to apply this standard in the fairest way based on an array of rates? How are appropriate geographic areas drawn for median rate determinations? We support excluding capitation products from consideration under this definition, but the rates involved should include “side payments” to providers as part of overall compensation arrangements with the plan, bonus amounts and withhold payments in order to ensure that the true amounts actually paid are properly calculated.

Second, there is wide variability in how in-network and out-of-network rates are determined. How will providers and practitioners know that plan’s usual and customary rate, and that such rate means the actual total payments made with respect to the services rendered during the period in question? The litigation over the use of Ingenix-based data and related matters has made it clear that regulators and providers need the ability to verify this information and provide for enforcement penalties when they cannot be verified. How will regulators capture rate information as a way of protecting patients and providers? Transparency of the plan’s data will be critically important to establishing trust and confidence in the process.

We further support the concept of balance billing patients in a fair and appropriate manner, and appreciate that PPACA and HHS have advanced this policy. We support the proposed federal standard with regard to balance billing, and believe the HHS policy properly addresses the need for federal preemption of conflicting state laws. We urge HHS to make clear that the PPACA policy on balance billing addresses the issue for all plans which are properly within the scope of PPACA coverage. Additionally, HHS should clarify that the PPACA policy also trumps state laws that limit the amount of balance billing below the levels permitted by this new federal policy as a matter of fairness and equity.

The FAH appreciates the opportunity to comment on the Rule. If you have any questions about our comments or need further information, please contact me or Jeff Micklos of my staff at (202) 624-1500.

Sincerely,

