American Hospital Association

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October 1, 2010

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

RE: Department of Health and Human Services; Office of Consumer Information and Insurance Oversight; File Code OCIIO-9989-NC, Request for Comments Regarding Exchange Related Provisions in the Patient Protection and Affordable Care Act, (Vol. 75, No. 148) August 3, 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 respond to the Office of Consumer Information and Insurance Oversight (OCIIO) request for comment on the exchange-related provisions in the *Patient Protection and Affordable Care Act* (ACA).

The AHA supports the creation of health insurance exchanges (Exchanges) as marketplaces to not only expand consumers' access to health insurance coverage, but also allow consumers the opportunity to choose health plans that fit their needs. With the proper framework and guidance, the Exchanges will ensure the efficient operation of a marketplace for private health insurance.

Our comments focus on the need for Exchanges to possess the following characteristics:

- Flexible enough to accommodate local conditions;
- User friendly for consumers;
- Efficient to attract private insurer participation while balancing key objectives of pooling risk and managing public subsidies; and,
- Small in focus initially with only the basic elements needed to allow the marketplace to develop.

In developing the regulatory framework for the Exchange, it is paramount that the OCIIO not confuse the purpose of the Exchange – to create an efficient private insurance marketplace for insurance carriers and consumers – with large scale regulation of the health care marketplace.

STATE FLEXIBILITY

The Secretary of Health and Humans Services (HHS) can choose to be either prescriptive or flexible in defining the scope and authority of the Exchanges. The AHA recommends that the Secretary strike a balance between the need to ensure that all Exchanges meet minimum requirements and the need for state flexibility – enough flexibility for states to design and implement the Exchanges to suit the unique needs of their populations and health delivery systems.

STATE EXCHANGE GOVERNANCE AND OPERATIONS

The ACA suggests that the Exchanges be operated by a state agency or a private nonprofit entity. We recommend that the Secretary encourage states to adopt independent quasi-governmental or nonprofit entities to operate the Exchanges for several reasons. This type of governance entity will:

- Focus the Exchange on its primary mission, that is, to create a competitive marketplace for consumers to purchase coverage;
- Grant the Exchange flexibility in hiring practices to ensure a professional workforce;
- Generate broad financial support that is crucial to the Exchanges' future stability; and,
- Increase the likelihood that the Exchange will attract a broad base of stakeholder support.

STATE EXCHANGE FUNCTIONS

The Exchanges will be tasked with key functions, such as the health plan certification and rating system, network adequacy, and enrollment of consumers in the private market and, when eligible, in public programs such as Medicaid and Children's Health Insurance Program (CHIP). These functions will be difficult enough without adding regulatory burdens such as provider rate setting, as some have suggested. The AHA recommends that the Secretary encourage the states to start small by focusing first on the mechanics of providing an efficient private health insurance marketplace for consumers.

The AHA is concerned that the OCIIO has already ventured down a slippery slope on the question of provider rate setting with the issuance of the Interim Final Rule (IFR) that implements the ACA's new patient protections requiring 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 IFR includes provisions setting minimum compensation rates to be paid by insurers to out-of-network providers for emergency services. That sum is the greatest of three possible amounts:

- The median amount negotiated with in-network providers for the same services;
- 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 charge); or

- The amount that would be paid by Medicare.

The AHA believes this provision, as written, will create a disincentive for insurers to engage in good faith negotiations with providers, resulting in unreasonably low payments for emergency services rendered by out-of-network providers and even larger balance bills for consumers. As such, this approach may benefit only health plans, to the detriment of consumers and health care providers. Discouraging the Exchanges from engaging in overt regulatory methods such as provider rate setting will give the Exchanges the opportunity to develop a fair and competitive environment for insurers, providers and consumers. Our comments on the specific functions follow.

- ***Health Plan Certification.*** The federal law requires the Secretary to establish the criteria for qualified health plans that can be offered in the Exchange. The AHA recommends that the Secretary allow for a manageable range of plans to qualify including local health plans such as those offered by some hospital and physician-based integrated health systems. The criteria should be broad enough and consistently applied to create a competitive environment within the Exchange and to better facilitate plan oversight, without allowing individual insurers to flood the Exchanges with large number of plans that have only minor differences.

- ***Network Adequacy.*** The ACA requires qualified health plans to meet criteria to ensure that network-based plans offer an adequate provider network, including community providers. The AHA recommends that the Secretary establish specific network adequacy criteria for qualified health plans. The AHA further recommends that any quality measures the Secretary establishes for qualified health plans offered through the Exchanges should include network adequacy. The criteria for network adequacy must be clear, measurable parameters that reflect the population and the region.

  The criteria need to ensure not only the participation of a sufficient number, mix and geographic distribution of providers, but also actual provider access for consumers. Specifically, there needs to be a mechanism to ensure that a health plan has an adequate network and sufficient capacity to accept new patients both initially and throughout the plan year. Health plans need to prove that consumers will be able to access necessary services at a reasonable distance and in a reasonable timeframe to address their particular health care needs. The criteria could include requiring health plans to submit encounter data to the relevant state agency to evaluate whether the enrollee is actually receiving services and is not being required to travel unreasonable distances to do so. Regular monitoring would help ensure that plans are not operating "shadow" networks (networks that list providers but do not ensure they are accepting new patients under that plan).

  In addition, health plans should be able to demonstrate that they have the capability to process claims payment for their entire network on a timely and accurate basis. The Secretary could consider using the Medicare Advantage network adequacy standards as a starting point for establishing criteria while carefully reviewing current problems (for example "shadow" networks, untimely and inadequate claims payment and overly generous mileage requirements for access to providers) within the Medicare Advantage standards to target specific changes.

- ***Quality and Price Requirements.*** The federal law requires the Secretary to develop a health plan rating system on the basis of quality and price to be used by the Exchanges. The AHA believes it is imperative that the quality criteria developed by the Secretary be based on nationally recognized, consensus-developed quality standards that can be consistently and uniformly applied and measured.

- ***Enrollment.*** The Exchanges must establish enrollment periods and enroll any eligible individual seeking coverage into public state programs, such as Medicaid and CHIP. With regard to enrollment periods, the AHA recommends that the Secretary allow and encourage the state-based Exchanges to limit the enrollment periods to minimize the potential for adverse selection.

  The challenges confronting Exchanges with regard to the interface with Medicaid and CHIP for purposes of enrollment are daunting. Beginning in 2014, the individual mandate will become effective and upward of 16 million people will become eligible for the state Medicaid programs. The Exchanges and hospitals are likely to bear the initial brunt of individuals seeking coverage with hospital emergency departments serving as one of the first points of entry into the health care system for many uninsured.

  Ensuring the utmost coordination between federal agencies and states with regard to enrollment information, including income data, is a priority. The HHS Office of the National Coordinator for Health Information Technology has developed a set of recommendations on enrollment standards. The AHA encourages the Secretary to consider a stronger hospital and provider role in the development of enrollment standards. Hospitals have extensive experience in helping patients identify and seek assistance for health insurance coverage, including working with Medicaid and CHIP. The Secretary also should consider other ways to assist states, such as the creation of federal electronic enrollment platforms that states could access, thereby eliminating the need to reinvent systems at the state level.

WAIVER AND NON-ELECTING STATES

The ACA allows states to opt-out of establishing Exchanges. If a state fails to establish an Exchange, the federal government will establish one in that state. If a state chooses not to establish an Exchange, it is imperative that the federal government work with key stakeholders, including providers and insurers, to make certain that the federal Exchange can meet the objectives of the federal law and provide meaningful access to insurance for the population in that state. In addition to the opt-out option, states can apply for waivers of numerous provisions of the ACA, including the individual mandate and the Exchanges. The AHA recommends that the Secretary establish clear waiver criteria so that states choosing to opt-out of ACA provisions do not create chaos in the private insurance market.

Clear federal guidance will go a long way in ensuring the successful implementation of the ACA and the establishment of health insurance Exchanges. The AHA looks forward to working with you and your staff to meet this challenge. If you have any questions about our comments, please contact Molly Collins Offner, policy director, at mcollins@aha.org or (202) 626-2326, or Ellen Pryga, policy director, at epryga@aha.org or (202) 626-2267.

Sincerely,

Rick Pollack
Executive Vice President