Greater New York Hospital Association
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Kenneth E. Raske, President

August
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2010

Mr. Jay Angoff
Director
Office of Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
Attention: OCIIO-9994-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

Dear Mr. Angoff:

The Greater New York Hospital Association represents the interests of more than 150 hospitals throughout New York State, New Jersey, Connecticut, Pennsylvania, and Rhode Island. All of GNYHA's members are either not-for-profit, charitable organizations or publicly sponsored institutions. Together, they provide services that range from state-of-the-art, tertiary care to the most basic primary care, given their roles as safety net providers for many of the communities that they serve.

I am writing to you in regard to interim final regulations published by the Department of Health and Human Services on June 28, 2010, implementing certain patient protections enacted by the Patient Protection and Affordable Care Act (the Act). We greatly appreciate the opportunity to comment on these important new protections and would like to specifically address provisions relating to coverage of emergency services. The Act amended the Public Health Service Act to prohibit insurers from imposing cost-sharing requirements for emergency services provided by out-of-network providers that exceed in-network cost-sharing requirements. The definition of cost sharing, however, excludes the difference between the amount a provider charges and the amount allowed by the plan. This amount may continue to be balance billed to the patient.

In order to assure that patients are not subject to unreasonable balance billing amounts, the proposed regulations require that plans pay a reasonable amount for out-of-network emergency services. Reasonableness is defined as the greater of the following: (a) the amount negotiated with in-network providers, excluding applicable cost sharing; (b) the amount calculated using the same method the plan generally uses to determine payments for out-of-network services (such as usual and customary charges), excluding applicable cost sharing; (c) the amount that Medicare would pay, excluding applicable cost sharing. We believe the purpose of this provision is not to regulate provider payment rates but to protect consumers from unreasonable out-of-pocket

expenses by assuring that the amount paid by the insurer is reasonable. Such protection is not needed where States have hold-harmless provisions that protect patients receiving emergency services from non-participating providers. For example, New York requires that HMOs reimburse emergency services received out-of-network with the patient liability limited to the in-network copayment amount. HMOs generally pay hospital charges for these services, unless an alternate amount is agreed to. Since patients are held harmless in these situations and the statutory intent of this provision is patient protection, there is no need and no basis for imposing regulatory standards for insurer payments to providers. It is our view that any reasonableness test should only be applied where patients are required to pay the excess of the amount the provider charges over the amount the plan or issuer is required to pay. We respectfully request that this be clarified in the final regulation.

Again, thank you for the opportunity to provide comments. We look forward to continuing to work together to implement this landmark legislation.

Sincerely,

Kenneth E. Raske
President