



Michael D. Maves, MD, MBA, Executive Vice President, CEO

August 12, 2010

Jim Mayhew  
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

Attention: OCIO-9991-IFC

Dear Mr. Mayhew:

The American Medical Association (AMA) appreciates this opportunity to comment on the Interim Final Rule and Proposed Rule (Rule) (75 FR 34538 et seq) concerning Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act (ACA). The ACA inaugurated a new paradigm by not only extending health care coverage and benefits to millions of individuals who were previously uninsured, but also by eliminating a system that encouraged health insurance issuers and plans to provide coverage and benefits to healthy patients and not to those most in need of coverage and benefits—patients with chronic and acute medical conditions.

The Rule represents an excellent attempt to strike a balance between ensuring continuity of coverage through grandfathered status and enhanced consumer protections through new plans in a manner consistent with the ACA. The AMA believes, however, that without the incorporation of additional triggering events, many individuals' access to care will be hindered, if not denied—a result inconsistent with ACA's underlying intent. As a general matter, the AMA believes that any materially adverse change in the benefits, or the rights to enforce those benefits, should result in a plan's loss of its status as a "grandfathered plan."

The subsequent discussion identifies additional changes to the Rule that the AMA believes will render the Rule fully consistent with the intent of the ACA.

***The Rule should state that a change from insured to self-insured status triggers loss of grandfathered status***

A grandfathered plan's conversion from insured to self-insured status is a material adverse change that should result in the loss of grandfathered status. Over the course of the past twenty

years, all states and the District of Columbia have adopted “patient protection” statutes and regulations designed to ensure that health insurers and plans do not engage in practices that might hinder patient access to care and that require health insurers and plans to deal fairly with all patients and providers. Such protections include, but are not limited to, state requirements enumerated under ACA section 1324 (Level Playing Field), i.e., state laws relating to: (1) guaranteed renewal; (2) rating; (3) preexisting conditions; (4) non-discrimination; (5) quality improvement and reporting; (6) fraud and abuse; (7) solvency and financial requirements; (8) market conduct; (9) prompt payment; (10) appeals and grievances; (11) privacy and confidentiality; (12) licensure; and (13) benefit plan material or information. Assuming a grandfathered plan is insured, it must conform to these requirements and structure its rights and obligations accordingly.

However, because of the preemptive effect of the Employee Retirement Income Security Act (ERISA), a self-insured plan need not comply with those aspects of state laws that ERISA preempts and the plan is also immune from state insurance commissioners’ enforcement powers. Unless a grandfathered plan, which was originally insured, voluntarily agrees to continue to comply with previously applicable state obligations subsequent to assuming self-insured status, which is an unlikely prospect, the plan will no longer be required to structure itself and operate in conformity with these state-based rights and obligations. The inapplicability of state requirements is likely to result in the re-emergence of market conduct and business practices which, while perhaps not altogether eliminating previously-provided benefits that would trigger the application of the Rule as initially drafted, will assuredly result in a reduction of enrollees’ ability to access, and providers’ ability to provide, those benefits. The ACA provisions that do not apply to grandfathered plans include all the following:

- Sec. 2713. Coverage Of Preventive Health Services.
- Sec. 2715a. Provision Of Additional Information.
- Sec. 2716. Prohibition On Discrimination In Favor Of Highly Compensated Individuals.
- Sec. 2717. Ensuring The Quality Of Care.
- Sec. 2719. Appeals Process.
- Sec. 2719a. Patient Protections.
- Sec. 2793. Health Insurance Consumer Information.
- Sec. 2794. Ensuring That Consumers Get Value For Their Dollars.
- Sec. 2702. Guaranteed Availability Of Coverage.
- Sec. 2703. Guaranteed Renewability Of Coverage.
- Sec. 2705. Prohibiting Discrimination Against Individual.
- Sec. 2706. Non-Discrimination In Health Care.
- Sec. 2707. Comprehensive Health Insurance Coverage.
- Sec. 2709. Coverage For Individuals Participating In Approved Clinical Trials.

For example, many states ensure that enrollees have direct access to specific kinds of specialists, e.g., gynecologists. These requirements do not apply to self-insured plans, and the detrimental effect of their inapplicability on benefit access will only be offset if conversion to self-insured status triggers a loss of grandfathered status, since only then will ACA sections like 2719a on

Patient Protections apply. ACA conferred grandfathered status on coverage and plans as a means of assuring that enrollees could retain their pre-ACA coverage subsequent to ACA's enactment and implementation. In many cases, the content of this coverage was contingent on rights and responsibilities defined by applicable state laws and regulations, particularly patient protection requirements. Rendering those laws and regulations inapplicable by means of a conversion from insured to self-insured status is likely to negatively affect that coverage.

***A reduction in, or refusal to appropriately expand, provider networks should trigger loss of grandfathered status***

A reduction in, or the refusal to expand, the number, specialties or geographic locations of the network providers utilized by a group health plan or health insurance issuer can significantly hinder enrollees' ability to access the benefits that they are entitled to receive under the terms of their plan or coverage. Enrollees pay health insurance premiums with the understanding that they will be able to obtain the services of network physicians and health care providers at discounted rates to which those contracted physicians and health care providers have agreed. If a network lacks a class of specialists who can provide a purported benefit, the benefit will in most cases be illusory, since many enrollees will either be unable or unwilling to pay the increased costs necessary to access the services of non-contracted specialists. Even if a network contains a class of needed physicians, a reduction in the number of those physicians, or a refusal to expand the number of contracted providers in that class, can create a formidable barrier to access. For example, although a plan or health insurance issuer may purport to provide a particular benefit, an inadequate number of physicians who can provide that benefit can greatly hinder access due to inordinately long wait times before the physician can actually examine and/or treat the enrollee or because patients are only able to access physicians by traversing long distances.

ACA's grandfathering provisions are grounded on the assumption that enrollees wish to retain their pre-ACA coverage because they were satisfied with the access that such coverage provided to them. These access issues are most acutely felt by patients with chronic or acute medical conditions—those for whom health insurance is most important. Because a reduction in, or a refusal to increase, the number of network physicians and health care providers can adversely affect the access to health care that ACA was intended to achieve, such a reduction or refusal should trigger a loss of grandfathered status.

***A reduction in medications available through a drug formulary should trigger loss of grandfathered status***

Similarly, a reduction in the numbers or types of drugs included in a prescription drug formulary, or the inclusion of additional cost-sharing obligation imposed with respect to certain drugs, is a material adverse change that should result in a loss of grandfathered status. These types of changes are most acutely felt by those enrollees suffering with chronic or acute medical conditions, and for whom health insurance coverage is most important. While the AMA certainly supports the use of less expensive generic medications when those medications meet patients' needs, many patients, e.g., those with chronic conditions like epilepsy or psychiatric

Jim Mayhew  
August 12, 2010  
Page 4

disorders, have been stabilized on a particular medication after many extensive trials using other drugs. It is devastating for these types of patients to lose access to such drugs, which are the types of essential benefits to which ACA is designed to ensure access.

***Other materially adverse changes***

The promise of the ACA is a health insurance system focused on optimizing patient health and welfare, rather than maximizing the number of *healthy* patients in a health plan. A benefit or provider network change that materially jeopardizes the ability of patients with acute or chronic conditions to continue to access pre-ACA health benefits should result in a loss of grandfathered status.

Thank you very much for considering these comments.

Sincerely,

A handwritten signature in black ink that reads "Mike Maves". The signature is written in a cursive, flowing style.

Michael D. Maves, MD, MBA