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Group Health Plans and Health Insurance Coverage: Interim Final Rules for Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act

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General Comment

Attached please find comments submitted on behalf of the American Chiropractic Association.

Attachments

IRS-2010-0010-0046.1: Comment on FR Doc # 2010-14488

American
Chiropractic
Association

August 9, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO–9991–IFC
P.O. Box 8016
Baltimore, MD 21244–1850

Re: Interim Final Rule for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act

The American Chiropractic Association (ACA) is a professional society composed of doctors of chiropractic whose goal is to promote the highest standards of ethics and essential patient care, contributing to the health and well being of millions of patients. The ACA is the largest association in America representing the chiropractic profession.

Below are ACA's comments regarding the Interim Final Rule for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act.

The Context of the Discussion

The Patient Protection and Affordable Care Act (PPACA) was signed into law in March 2010 as the country's attempt to reform today's unsustainable health care system. If executed as designed, the implementation of PPACA will result in a $143 billion reduction in the federal deficit with the first positive effects occurring in 2012.[1] However, these numbers are uncertain and will likely change depending upon the rules that are used to actually implement the legislation. The Congressional Budget Office (CBO) has stated, "It is not clear what specific policies the federal government can adopt to generate the fundamental changes in the health care system. That is, it is not clear what specific policies would translate the potential for significant cost savings into reality."[2] If fundamental change does not occur, the costs will be much higher for everyone.

A significant amount of attention has been placed on Title I (Quality, Affordable Health Care For All Americans), insurance market reform. This section of the legislation is the most visible to the general public because it impacts the accessibility to health insurance for most citizens.

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[1]Congressional Budget Office; Doug Elmendorf Letter to Nancy Pelosi; March 20, 2010
[2] Congressional Budget Office; Doug Elmendorf Presentation to the IOM; May 26, 2010

However, as the rules are discussed and established for one segment it is critical to keep in mind the context of the other nine Titles. Only if all aspects of the legislation work together with a common goal and purpose will the intended results be realized.

The Employer Perspective

Employers spend nearly $5,000 for single coverage and slightly over $13,000 for family coverage annually.[3] For family coverage, this represents a 34% increase over the costs in 2004 and a 131% increase over what was paid in 1999.[4] The Robert Wood Johnson Foundation estimates that family health insurance coverage will increase to over $20,000 annually by 2020 if no changes occur.[5] This trajectory is obviously not sustainable for most businesses and they know it. However, while employers generally support the need for health care reform, they do not believe the current effort will have a positive impact on health care costs. Most believe health care reform (as they currently understand it) will actually increase their costs.[6] When asked of the likely actions they would take to address the anticipated additional costs of health care reform 88% indicated they would likely pass these costs on to the employee and 74% indicated they would reduce health care benefits. Only 33% indicated they would absorb the costs within the business.[7] While these actions would likely trigger loss of grandfather status as defined in the interim rule, they may also create a desire to develop creative approaches for employers to maintain their grandfather status for as long as possible. Employers may not want to participate willingly until they believe health care reform will actually work.

The Consumer Perspective

According to a recent survey less than 25% of the health care consumers in this country believe they understand how the healthcare system works.[8] We have created a fragmented, confusing, expensive, and inefficient system that is generally difficult to navigate. This confusion has created a culture of mistrust of the system for the consumer, which impacts their level of engagement, informed decision-making, and support that will be required to create a sustainable and efficient health care system. Increased consumer engagement and understanding will be a key to success in implementing the insurance market reforms included in PPACA.

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[3]Kaiser Family Foundation and Health Research Educational Trust; 2009 Annual Survey
[4] ibid
[5] Robert Wood Johnson Foundation; The Cost of Failure to Enact Health Care Reform 2010-2020; March 2010
[6] Towers Watson; May, 2010
[7] ibid
[8]Deloitte Center for Health Solutions; 2010 Survey of Health Care Consumers

While most individuals understand the need for system reform, most think they will be worse off than they are today, when the current reforms are implemented. And, with good reason, most think employers will simply pass these increased costs on to them.[9]

Consumers view their health care as more than simply the schedule of benefits provided to them (what's covered, what's not covered, how much). They also look at the provider network, claims processing performance, communication, customer service, and other services as integral components of their health care plan. While cost is critical, the providers and other services associated with the plan are key components of the health care "product" as well.[10]

While employers have shouldered the burden of the cost of health care in the past, individual consumers are beginning to feel the financial impact more than ever. Over 40% of consumers today (and not only the uninsured) make the decision to forego medical treatment, prescriptions, and preventive screenings, due to the costs.[11]

Consumers know we need to change, but they would also like to have a system they can understand better than the one we have today.

Creating Another Segment- Grandfathered Group Health Plans

The Interim Final Rule for defining grandfather status of a group health plan justifiably relies on historical data to determine the potential impact on the current health care market. While historical data are useful, it is important to keep in mind that the fundamental way our economy and health care system operates has changed. The ways of the past may not necessarily be indications of the future, especially with the belief in the general population that health care reform will actually cost more than if things remained the same. The interim rule estimates that by using the seven identified triggers, on average (mid-line) 34% of small business plans (15 million individuals) and 55% of large businesses (73 million individuals) will continue to be operating largely outside of the PPACA when the major reform components become effective in 2014.[12]

The rule states, "The importance of gradual change outweighs the risk of market segmentation."[13] We disagree. The health care system in this country has already proven what occurs when separate and individual risk pools exist throughout a population. When separate arrangements are maintained over time, costs shift, consumers and administrators become even more confused, and the cost of managing and maintaining these separate arrangements are added

[9]Deloitte Center for Health Solutions; Deloitte Consumer Pulse Survey; Post Healthcare Reform Perceptions; June, 2010
[10]Deloitte Center for Health Solutions; 2010 Survey of Health Care Consumers
[11] ibid
[12]Draft Regulations on Grandfathered Health Plans; 6-11-2010
[13] ibid

to the health care system costs overall (including the consulting fees that may be required to make business decisions). Market segmentation, i.e., exclusion from exchanges, will also minimize the impact of any possible benefits of PPACA to individuals, and to addressing the unsustainable costs in our health care system today. Every effort should be made to remain fair to individuals and employers, but the focus should be on a strategy that results in fewer grandfathered plans, establishes perfectly clear and simple rules, minimizes the risk of further market segmentation, and avoids further confusion for the employer and the consumer.

The Rule

As stated, we believe it is important to maintain fairness to employers and employees and minimize any disruption of successful health care programs. At the same time, it is important to keep in mind the overall goal and components of the PPACA legislation. Our current system provides a case study for what occurs when you have separate markets operating independently: high cost, inefficiency, and confusion. The Massachusetts health care initiative has proven what can occur when you establish the processes to improve access but fail to restructure the health care delivery mechanism itself.

We believe both must work together. Therefore, every effort should be made to increase the number of individuals covered by PPACA, especially as of January 1, 2014 when most of the reform components (Insurance Exchanges, Subsidies, Tax Credits, etc.) come into play.

The Rule provides the seven triggers that would revoke the grandfathered status of a group health plan:[14]

- Mergers or acquisitions with the sole intention of maintaining grandfather status
- Elimination of substantially all benefits to treat a particular condition
- Elimination of benefits for any element necessary to eliminate or diagnose a condition
- Any change to coinsurance level
- *Fixed-amount cost-sharing* (Deductibles/OOP) Inflation +15%
- Co-payments (Medical Inflation +15% or $5 adjusted for medical inflation)
- Employer contribution (> 5% reduction in Employer Contribution)

While relatively straightforward, these guidelines may still result in some confusion to the marketplace in their application. For example, if an employer raised the copayment level beyond the maximum in one area (i.e. outpatient services) but retained the copayment level for primary care doctor visits, does that mean a loss of grandfather status? Clarity will be critical both for the employer and the employee.

[14] ibid

As previously discussed, the average consumer has a broad definition of "benefits." Consumers view their health plan beyond the covered benefits, cost sharing, and the contribution levels associated with the plan. Other components of health care services can have a significant impact on the individual employee, which can result in a change to their plan including:

- *A "substantial change" to the provider network*

  Consumers believe their provider and the provider network associated with any plan is an integral part of the health care benefits provided by the employer. A termination of a hospital system or specific provider group sometimes has significant impact on the employee population and should be viewed as a substantial change to the plan itself. As a guideline, we would suggest any change in the provider network impacting over 50% of the employee population (nationally or locally) should result in a loss of the grandfather status.

- *Change in issuer or third-party administrator (TPA) (including moving from fully-insured to self-funded)*

  Even if the benefit structure of a group health plan remains largely the same, a change in administration of the plan requires new communication, new processes, and new requirements on the part of an employee and the employer. Moving from a fully-insured to a self-funded status or changing administrators requires new processes and legal agreements for the group health plan. These transitions are not daily or regular events and should be considered a change in the group health plan.

- *Change in drug formulary or pharmacy benefit manager (PBM) administrator*

  Changes to a drug formulary can have a significant impact on the individual. While formularies are updated regularly, significant changes-- i.e. eliminating or changing the formulary with respect to the most highly prescribed prescriptions (top 10 prescribed within a population)-- can have a significant impact on an individual. Changes to the PBM administrators follow the same logic as a change in TPA. These changes should also be considered as significant enough to revoke grandfather status of the plan.

- *Significant change in care management/authorization requirements*

  The processes consumers need to follow to receive care are a significant component of their perceptions of their health benefits plan. Changing notification requirements, requiring referrals, or other care management strategies involved in the delivery of care should also be considered as a change to the plan. This may prevent group health plans from maintaining their grandfather status by not necessarily eliminating a benefit, but making it difficult to receive by changing the care management process around it.

Additional Suggestions for Care Management and Provider Contracting Activities That May Result In the Loss of Grandfather Status

It may be helpful to think of the potential changes to grandfather status for provider contracting, care management policies, and structure in the following construct: Are changes made to the administration of the group health plan a routine maintenance change to the product or plan that is typically performed on a regular (at least annual) basis? The following logic could then apply to determine the status of the group health plan:

- What do the internal policy and procedure documents dictate of the frequency and schedule of the activity?
- When was the last time this item was addressed, considered or changed?

If the plan policy (often times as outlined in quality improvement documents or in the department's internal operating procedures, e.g. network contracting) is to address this issue annually and it has made changes annually, (re-contracting, adding, dropping providers and health care systems) then this may be normal and routine maintenance. If there are no policies or procedures found indicating the established schedule has been maintained, then this should be considered a significant change and the plan should lose grandfathered status. As mentioned earlier, changes to the provider network can have significant repercussions for employees. For example, if there are only two contracted specialists in a county and the plan terminates one of those, this could require employees to travel unusual distances and thus render the service a "phantom" benefit for that population. The National Committee for Quality Assurance (NCQA) does have metrics for provider density, such as 30 minutes or 30 miles in rural areas, or 15 minutes/15 miles in higher density populations etc. that could be used as suggested industry models/standards.

Other changes that should be considered "substantial changes" pertaining to contracting and care management processes include:

1. Inserting language in the provider's contract that impacts the delivery of care to the consumer for health care services

    a. Including pre-authorization requirements for certain procedures or by a particular specialty or any other unusual burden added to the provider so as to create administrative obstacles that discourage providers from attempting to render that benefit

    b. Discouraging or creating barriers in the use of particular ICD or CPT codes. Again, the patient's plan would state they have that benefit, but the provider who is contracted to deliver that benefit would be restricted or dissuaded from rendering that service due to

administrative, financial, or performance (profiling) language in the provider's contract thus reducing availability to the end user, the consumer.

c. Any change to the provider's contract after March 23, 2010 that would change the availability of services to the consumer from those delivered prior to March 23, 2010 would result in the loss of grandfather status.

d. Any changes to the patient or provider's appeal process outside of what is required to obtain or maintain accreditation status

e. Establishing requirements to force providers to accept or contract to deliver services to *all* the Health Plan's products, including grandfathered products, or the plan can terminate the provider's contract (unless such language was in effect as of March 23, 2010).

f. Inserting provider contract language that would shift populations to particular provider groups (without appropriate changes to reimbursement, tiering, profiling, etc.)

In general, any changes in provider contracts that drive provider decision making in care (including provider tiering) or reimbursement should be considered as a substantial change, and any management, plan participation, provider profiling, contract addenda after March 23, 2010, should result in a relinquishing grandfather status of the group health plan.

2. Recognizing many incremental changes can result in a substantial change when viewed in the total context. As we have seen in past, incremental changes by health plans can have substantial impact on the chiropractic profession's ability to treat populations. These changes should not be considered *de minimus*. Some examples of this include:

An insurer who made the determination to no longer cover spinal manipulation performed with a hand-held device, when the thrust of the force is controlled manually. Although manipulation performed with a hand-held device is a covered service under Medicare, the insurer recently changed their policy to disallow coverage for this type of treatment. For patients who are elderly, have traumatic injuries, are post-surgery or pregnant, a hand held device provides an alternative method for administering manual spinal manipulation that can be beneficial to them given their current health conditions. This seemingly small change has had a severe impact on many patients who benefit from chiropractic manipulation using this method.

Another insurer implemented a policy to only allow coverage for spinal manipulation in conjunction with one therapeutic modality. From the insurer's perspective, this policy change may be viewed as a simple cost containment effort. However, for patients who need a comprehensive care approach to adequately address their symptoms, the policy now forces the patient to choose between foregoing treatment or choosing to pay out-of-pocket for care that is

medically necessary. Interestingly, under the same plan, if the patient were to visit a physical therapist, multiple therapy services would be permitted. Ultimately, patients have paid, through their insurance premium, for multiple therapies on a given date, and can access that care through other provider types, but are unable to access that care when seeing a doctor of chiropractic, which disrupts continuity of care and results in higher out of pocket expenses. In an effort to control costs, the insurer forces the patient to see a DC for the spinal care they need and then make a separate appointment for necessary therapy services, for them to be covered adequately. This causes duplicative examination costs and is unnecessary because DCs are licensed and trained to provide the therapy. It is in the insurer's and the healthcare system's best interest for patients who need a combination of skilled manipulation services and therapy to be permitted to seek such necessary care from a DC, if they so choose.

Multiple insurers have created policies that bundle therapy services with chiropractic manipulative treatment (CMT). In direct contradiction to both CPT and CCI edits, many insurers will bundle massage therapy, neuromuscular reeducation, trigger point therapy and/or many other soft-tissue techniques with CMT, causing the doctor to have to either write off the full amount or no longer provide the service. Despite the doctor's clinical decision that this care is necessary to treat the patient, and despite the fact that the two procedures would, if performed on separate dates of service, be covered, the insurer has determined that the two procedures cannot be billed together. These are covered services that the patient cannot access and there is no clinical research or coding authority that suggests there is a legitimate rationale for the practice of bundling them. This forces the patient to see the provider on separate dates of service and reduces the clinical efficacy of treatment.

An insurer recently instituted a policy that only reimburses doctors of chiropractic for the lowest-level chiropractic manipulative treatment code regardless of the number of regions manipulated. The three existing CMT codes, 98940, 98941, and 98942 were developed so that a doctor of chiropractic could accurately describe the work performed, i.e. the number of regions of the spine manipulated. By only paying for the lowest-level CMT, the insurers shirk their responsibility to pay for medically necessary chiropractic care, something the patient deserves if the plan is described as having chiropractic coverage. If the doctor determines that multiple regions are necessary, he or she is forced to perform this necessary higher level of service without appropriate reimbursement.

A self-insured plan administrator guided their plans to offer policies that only allowed MDs and DOs to perform spinal manipulation. Patients seeking non-invasive spinal care read in their policy (certificate of coverage) that they had a manipulation benefit, but could not find any MD or DO in their network who would perform manipulation; and doctors of chiropractic were not 'covered' providers for this skilled professional service, even though they are well known for performing the vast majority of these services (94%). The administrator and employer apparently created the policy under the assumption that since it was not outside the scope of practice of an MD or DO to perform manipulation this would be acceptable, however neither

group of providers routinely receive training in spinal manipulation in medical/osteopathic school. This policy coverage change effectively made the spinal manipulation benefit illusory, as no qualified providers of the benefit were available to the patient. **Summary**

Even by the most optimistic estimates, a substantial portion of the employee population will remain outside the PPACA as of January 2014 based on the current rules. While we understand the difficulty involved in making change, creating another large sub-population of excluded individuals will only add to costs, increase confusion, and mitigate the potential impact of the legislation. This only adds to the uncertainty surrounding the $143 billion in deficit reduction projected by the CBO when the process began.

The Rule needs to be clear, reasonable, and with no ambiguities involved in determining whether a group health plan is "in or out." The decisions we make today will determine the outcomes for tomorrow. We may need to make some difficult decisions to create a sustainable health care system that will support a growing economy in the future. That means getting as many citizens across the country participating at the beginning to make it work and delivering on its promises to retain their support.

Thank you for the opportunity to comment on this regulation.

Rick A. McMichael, DC
ACA President