

# American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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August 6, 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: OCHIO-9991-IFC**

Dear Mr. Mayhew:

The American Academy of Pediatrics (AAP), a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults appreciates this opportunity to submit comments regarding the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan (45 CFR Part 147, 26 CFR Parts 54 and 602, 29 CFR Part 2590).

The Academy believes that the regulation should impose much narrower criteria for a plan to retain grandfathered status. Clearly, the downstream benefits to children whose health insurance plans cover all nationally recommended preventive health services as first dollar coverage are superior to those who have limited preventive benefits because they are covered by grandfathered health plans. Pediatricians are reminded every day that children need more from their insurance carriers, and we would urge changes so that plans must comply with the Affordable Care Act's consumer protections more quickly than is contemplated in the interim final rule. Grandfathering existing plans should at best be a temporizing strategy to help plans move quickly and deliberately to compliance with the Affordable Care Act's legislative intent.

Thank you very much for your attention to the views of the American Academy of Pediatrics.

Sincerely,

A handwritten signature in black ink that reads "Judith S. Palfrey".

Judith S. Palfrey, MD, FAAP  
President

JSP: rh

**Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan (45 CFR Part 147, 26 CFR Parts 54 and 602, 29 CFR Part 2590):**

The American Academy of Pediatrics (the Academy) is dedicated to the health of all children. The Academy's Access Principles call for all children to have access to quality health insurance as well as all recommended and needed services. The Affordable Care Act lays the groundwork to achieve this goal, with its focus on preventive services and essential benefits in Exchange plans. Nevertheless, the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan (the Grandfather Regulation) needlessly excludes millions of children from accessing the services they need from appropriate clinicians right now.

Overall, the Academy congratulates the Departments of Treasury, Labor and Health and Human Services (the Departments) on crafting a rule designed to strike a balance between continuity of coverage and consumer protections. Nevertheless, the Academy would prefer narrower criteria for plans to retain grandfather status. This is because a loss of grandfather status leads to such positive results for insured children. In particular, access to no copay-preventative services and the ability to choose a pediatric primary care provider are important to children's health, but grandfathered plans are required to provide access to neither of these important benefits.

The importance of prevention. The Grandfather Regulation creates a regime in which families may find it harder to access the preventive services that their children need in grandfathered plans. While cost is an important issue for health insurance, adding no copay preventive services and other consumer protections should not raise cost precipitously for plans, and will certainly save costs for society as a whole. In particular, preventive services like immunizations and well child visits have a strong return on investment and making them more readily accessible is clearly within the spirit of the Affordable Care Act. With these arguments in mind, the Academy believes that the new consumer protections from the Affordable Care Act should apply to as many plans as possible, and therefore, would urge that the retention of so-called grandfather status be a much more difficult proposition than is set forth in the Grandfather Regulation. All children need preventive services, and discouraging families from using them (the rationale for cost sharing) for years can be devastating to children. This policy also leads to unnecessary cost for the system because the focus of pediatric prevention is to detect and address health problems early.

Because of the quality and importance of the Bright Futures program, in fact, we would urge the Departments to consider making no-copay access to Bright Futures services mandatory for all public and private insurance coverage in the United States.

Choice of clinician and the medical home. Of particular concern beyond preventive services, the Grandfather Regulation allows plans to continue to auto-assign families to non-pediatric clinicians, as well as limit access to pediatric clinicians by modifying provider panels. Both of these loopholes have the potential to fragment care and undermine the medical home.

The Academy started developing the concept of the medical home in the 1960's. Every child deserves a medical home, which is a trusting partnership between a child, a child's family and

the pediatric team who oversees the child's health and well-being within a community-based system that provides uninterrupted care with appropriate payments to support and sustain optimal health outcomes. Medical homes address preventative, acute, and chronic care from birth through transition to adulthood. A medical home facilitates an integrated health system with an interdisciplinary team of patients and families, primary care physicians, specialists and subspecialists, other health professionals, hospitals and healthcare facilities, public health and the community. The Academy developed the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to every child and adolescent.

Not every child in the United States, unfortunately, has access to a medical home, and one of the major problems with health insurance for families with children at this time is the amount of churning that occurs from year to year.<sup>1</sup> Turnover and churning disrupt continuity of care, create burdens for families, pediatricians, and administrators and produce inefficiency in the health system generally. High churning and turnover rates increase administrative costs for private health plans and public programs.<sup>2</sup> Families care about staying with a medical home, not a particular insurance company. Plans should be discouraged from disrupting a family's ongoing relationship with their medical home by precipitously restricting the size and scope of provider panels. Plans should forfeit grandfather status if they do not.

In a worst case scenario under the Grandfather Regulation, access to entire categories of pediatric subspecialists could be cut off for children and youth with special health care needs (CYSHCN) by a plan that would still retain its grandfather status. CYSHCN live in one of every five US households. While constituting only around one-sixth of the child population, CYSHCN utilize around 40% of the overall health care "spend" of the pediatric population. For their health insurance to be meaningful, CYSHCN must have access not only to pediatric primary care but also adequate access to pediatric medical subspecialists and pediatric surgical specialists. Thus, we would urge the Departments to also specifically include access to pediatric specialists for this population as a prerequisite for continuing grandfather access, because coverage of benefits while eliminating specialists from a provider panel will not allow for real access to services for this vulnerable pediatric population. Limitations on access to subspecialty providers would be particularly acute in rural areas where current access to pediatric subspecialists in a particular provider panel can be close to non-existent.

To determine an appropriate standard, we would urge the Departments to evaluate whether the Medicaid provider network rules would be appropriate in this context for application to the private market. Whatever standard is used, we urge the Departments to remember the needs of children, and in particular CYSHCN, to ensure that all plans include provider networks that are adequate to meet their needs.

Other reasons that grandfather status should be more difficult to retain. The Academy has concern that there can be other significant changes made by plans that do not lead to a loss of

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<sup>1</sup> Laura Summer, M.P.H., and Cindy Mann, J.D., "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies." June 16, 2006, Commonwealth Fund Publication no. 935.

<sup>2</sup> See, "Uninsured Children: How We Count Matters," Pediatrics 2003;112:e168-e173 by Suk-fong S. Tang, Lynn M. Olson and Beth K. Yudkowsky.

grandfather status. These include first, change of plan structure, either through a transition from Point of Service Plan (POS), Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or becoming self-insured. A second concern regards changes to formularies. A third concern is an employer's decision to withdraw family coverage.

First, and with the recognition that loss of grandfather status can lead to positive protections for children, the Academy would advocate that plan structure changes should lead to loss of grandfather status. This would include a modification from a POS structure to PPO or HMO, or a transition from a PPO to HMO or POS.

The Academy is also deeply concerned that grandfathered plans will increasingly move to being self-insured. As this could be an attempt to avoid important consumer protections applicable to state-regulated plans, the Academy suggests plans that change structure to become self-insured should forfeit grandfather status. In particular, Academy member have had repeated difficulty in encouraging self-insured plans to pay appropriately for vaccine administration.

Second, significant changes to formularies should cause a plan to lose grandfather status. In particular, if a plan adds a new tier of high-cost drugs, there could be a tremendous impact on cost to CYSHCN families needing multiple prescriptions. Additionally, we would urge the Departments to clarify rules on inventory generics, and to limit a plan's ability to move drugs or classes of drugs to higher cost tiers without forfeiting grandfather status.

Third, we urge the Departments to clarify that rescinding family coverage will lead to a loss of grandfather status. It appears unclear from the Grandfather Regulation whether an employer's decision to move to "spouse only" coverage from family coverage will lead to a loss of grandfather status. If a plan moves to rescind coverage for children, the Academy would urge that grandfather status should be forfeit.

Enforcement and Communication. The Academy has also noticed the general lack specific enforcement authority for the federal government in many of the regulations being promulgated under the Affordable Care Act. Every day, pediatricians employ office staff to negotiate with insurance companies to pay them for the services they provide. These interactions can lead to denials for payment that pediatricians deem medically necessary for the patients they care for. We urge the Departments to set up enforcement mechanisms that will police whether insurance companies are complying with federal laws regarding the loss of grandfather status. At this time, it is not at all clear what would happen to a plan that loses grandfather status, but does nothing differently. Children can clearly lose when a plan simply violates the law, claiming grandfather status inappropriately.

Finally, we urge the Departments to keep the lines of communication open to on-the-ground clinicians to solicit feedback regarding whether rules like the Grandfather Rule are working in practice for the benefit of the patients to whom we provide care. Please establish mechanisms for pediatricians to act appropriately and efficiently on behalf of patients in interacting with plans. We urge you to establish easy ways for the patient to receive information through the pediatrician about what having a grandfathered plan means.