Adventist
HEALTH SYSTEM

August 16, 2010

Mr. Jay Angoff, Director
Office of Consumer Information & Insurance Oversight
Department of Health & Human Services
Attention: OCIIO-9991-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

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

Dear Mr. Angoff,

Thank you for the opportunity to provide comments on the interim final rule for Grandfathered Health Plans.

I am writing on behalf of Adventist Health System, which operates 27 hospitals in 10 states. Our flagship hospital, Florida Hospital in Orlando, is the nation's largest Medicare provider. Our comments follow.

1. **Language Clarification for the Definition of a Qualified Health Plan**: The language in Section 1 (Background, page 34539) is unclear as to whether this rule applies to self-insured group health plans. In one section, it states that it "includes both insured and self- insured group health plans." At the bottom of the same column, a footnote says, "The term 'health plan' does not include self-insured group health plans."

   Overall, our reading of the Act leads us to conclude that self-insured plans are excluded generally from the definition of a Qualified Health Plan.
   - Subpart D, Part I (b) (1) (B), expressly excludes self-insured plans from the definition of a Qualified Health Plan.
   - Self-insured plans are subject to certain fees but this does not necessarily mean that they are subject to the Affordable Act in its entirety.
   - Sections 1253 and 1254 call for a study and annual reporting on self-insured health plans; this implies that a decision on regulating these plans under the PPACA remains an open issue. Because CMS appears to have significant latitude in their rule making, it would appear judicious to wait for the studies on self-insured plans before making them subject to the grandfathering provisions that may be most appropriate for market-based plans.

2. **Changes in Treatment Modalities**: A provision in Section F (Maintenance of Grandfathered Status, page 34543) states that the elimination of all or substantially all benefits for diagnosing and treating a particular condition would cause a plan to lose its grandfathering status.
   - It is unclear if the elimination of a particular modality of treatment would trigger this provision. For example, if a plan covered Radiation Therapy, IMRT, and

Proton Beam for prostate cancer but eliminated Proton Beam coverage (only), would that trigger the other provisions relating to grandfathered status?
- What will govern coverage decisions based upon clinical or Comparative Effectiveness Research?
- Will all such changes become de- grandfathering events?

3. **Increases in Cost-Sharing**: Section F (referencing Paragraph (g) of 26 CFR 54.9815-1251T et. Al) states that any percentage increases in cost sharing (such as coinsurance) will cause a plan to be de-grandfathered. While this concept may be warranted and there may be data to support it, Section F does not include the reasoning for it. Further, it is possible that these economic times may spur percentage cost share changes. We believe that this rule – to be consistent with other criteria for grandfathering –should not be an all-or-nothing proposition.

4. **Economic Indicators**: Many of the parameters for what will and will not be permitted are to be based on 2008-2009 studies. We are not sure that these studies are necessarily reflective of the behavior of insurance companies and employers in response to the 2009-2010 recessions.
   - The assumption on p. 34551 (item b) is that economic conditions will improve in 2011 – and put less pressure on employers to reduce their contributions. We believe this may be overly optimistic. Even when the economy improves, employers will be regrouping and looking to reduce operating expenses.
   - We suggest a less sanguine view of the future – or at least a temporizing of criteria – until there is a better sense of what is happening economically. Otherwise, as proposed in this rule, many more plans than estimated will be forced to give up their grandfathered status. This could lead to more people losing their existing plans.

5. The Department has invited comments on a variety of areas that could affect grandfathering status:
   A. **Changes in health structure:** This section addresses changes from health reimbursement to major medical coverage, or from an insured to a self-insured product. We do not believe that such changes per se would be a de-grandfathering event. However, any structural changes in coverage and financial exposure to the enrollee – consistent with the provisions in the interim or final rule – would certainly be relevant.
   B. **Changes in a plan's provider network**: A change in and of its self should not be a triggering event. Concerns should arise if the change created material impacts on access and the use of out-of-network providers – and increased enrollee costs.
      - The impact of changes would vary based upon the capacity of physicians and outpatient services, but it would seem that a decrement in 10% of primary care and 5% of specialists would warrant consideration for de-grandfathering.
      - An increase in out-of-network claims could be a way of measuring the impact of a change. If a network change created a 5-10% volume increase in out-of-network claims – which always results in the enrollee paying more – there would be sufficient reason to say that there was a plan change.

   C. **Changes in formulary:** Formulary changes are very dynamic. Drugs come off patent, generics become available, and what were prescription drugs become OTC medications.

- As long as a plan did not change the formulary to exclude types of drugs that were available to treat a specific condition, e.g., drugs to treat allergies, then the plan has not significantly changed.
- The exception would be in psychotropic medications. If a formulary included Atypical Psychotropic Medications (APM) but dropped their coverage, this would be a material change in coverage. While APMs are more expensive, they have demonstrably fewer side effects and result in significantly higher compliance. Dropping these drugs from a formulary would be tantamount to reducing coverage for severely mentally ill individuals.

D. **Other substantial changes to overall benefit design:** This subject area will require much more consideration before it is incorporated into a rule. Benefit design must be an evolving area, especially in the area of public policy and Comparative Effectiveness Research.
   - Benefits design may substantially change in order to reflect the development of sounder public policy. For example, the PPACA places greater emphasis on prevention and primary care rather than interventional care. As this becomes a proven concept in terms of better outcomes and reduced utilization, plans will need to change to encourage or reward this enlightened approach. It would not seem fair to take away the grandfathered status because than made substantive changes that are in the best interest of the enrollees.
   - Evidenced-based medicine and Comparative Effectiveness Research should be the determining factors in all instances.

Again, we appreciate the opportunity to comment, and thank you for your attention to our suggestions.

Please feel free to contact me at 407-303-1607 or rich.morrison@flhosp.org with any questions or comments.

Respectfully,

Richard E. Morrison
Corporate Vice President

cc: Donald L. Jernigan, President & CEO