AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
Executive Vice President, CEO

American Medical Association
515 N. State Street
Chicago, Illinois 60654

ama-assn.org

(p) 312.464.5000
(f) 312.464.4184

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Marilyn B. Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Patient Protection and Affordable Care Act; the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,118 (December 7, 2012); File Code CMS-9964-P

Dear Acting Administrator Tavenner:

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed regulation on Benefit and Payment Parameters for the 2014 (Proposed Rule) published in the Federal Register on December 7, 2012. The AMA has long advocated for greater transparency in the health insurance market, including mandating premium transparency and medical loss ratio information.

The AMA strongly believes that physicians and other health care professionals must have accurate, binding, real-time information so that they are aware when a patient's health care enrollment in a health insurance plan has been terminated. As we have stressed previously, insurers should not be able to pend claims for 60 days without any notification to physicians, and then ultimately deny payment for care already provided, thereby transferring the burden of non-payment to physicians.

Medical Loss Ratio

As a practical matter, the implementation of the Medical Loss Ratio provisions of the Patient Protection and Affordable Care Act (ACA) has created increased transparency and other benefits for consumers. Notably, the Commonwealth Fund recently reported that health care

insurers paid nearly $1.5 billion in rebates as a result of having to spend at least 80 percent of premium dollars on health care or quality improvement activities rather than on administrative expenses, including overhead, marketing, and profit.

The AMA continues to advocate for strict limitations on how "quality improvement" and "administrative expenses" are defined. While the Proposed Rule, in part, amends the dates for which issuers must disburse future rebates, which may delay rebates for consumers, we commend CMS for continuing to require insurers' transparency on how they calculate the Medical Loss Ratio. We reiterate our support for actuarially sound, accurate, timely, and consumer-meaningful data submission. This data, moreover, must be publicly available so that patients have information showing what value they receive for the premiums they pay.

Grace Period

We are very concerned by the Proposed Rule's linkage of payment for cost-sharing reductions to a significant provision first outlined in the Exchange final rule (CMS–9989–F), which would allow health insurance issuers to pend claims for the final 60 days of the 90-day grace period when a patient is having his or her coverage terminated for non-payment of premiums. Section 156.430(f) of the Proposed Rule addresses cost-sharing reductions provided during grace periods following non-payment of premiums, and aligns with the ability of issuers to pend claims and payments for cost-sharing reductions for services rendered to patients in the second and third month of the grace period. CMS must consider other options to minimize the impact of the ability of insurers to pend claims before the exchanges become operational.

By authorizing health insurance issuers to pend claims for the final 60 days of the 90-day grace period when a patient is having his or her coverage terminated for non-payment of premiums, CMS unfairly shifts this burden to physicians and other health care providers and puts them in the position of potentially providing health care to patients for two months without payment. Without further changes to the Proposed Rule as well as the Exchange final rule, the 60-day grace period for insurers is a major disincentive for physicians who are considering participating in qualified health plan networks.

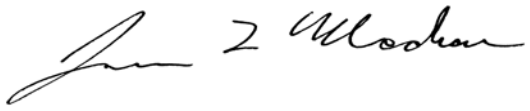
If the Proposed Rule as well as the Exchange final rule are unaltered before exchange implementation, we continue to urge HHS to ensure that exchanges require qualified health plans (QHPs) to provide accurate, binding, and real-time notification to physicians and other health care providers, so that they are aware that patients are entering the second month of the grace period and that claims submitted on their behalf may be pended and ultimately denied. We also urge HHS to investigate with physicians, hospitals, and health insurance issuers the best ways to accomplish this, preferably through electronic transaction notifications and traditional routes, such as certified mail.

As stressed previously in our comments in response to the Exchange final rule, we also note that, while proper notification may mitigate some of the problems caused by the grace period, it fails to address situations where the patient and the physician and/or hospital do not have a pre-existing relationship. Without accurate, binding, and real-time information and without notice, the physician or the hospital would not have any knowledge that the patient is in the grace period and that the QHP will pend his or her claims.

As an alternative to pending claims during the grace period, the AMA has previously suggested having exchanges use reinsurance to cover these situations. We continue to believe that reinsurance would help to address the scenario where the patient does not have an already established relationship with a physician or a hospital. It would also help to spread the financial burden, so that individual physicians or small hospitals do not bear the brunt of the termination of patient coverage due to non-payment of premiums.

In conclusion, the AMA appreciates the opportunity to provide input on the Proposed Rule, and we look forward to continuing to work with CMS on implementation of this key aspect of the ACA.

Sincerely,



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