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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John Berry
Director
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

Re: Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges (RIN 3206-AM47)

Dear Director Berry:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am writing to offer our comments regarding the proposed rule issued by the Office of Personnel Management (OPM) to implement the Multi-State Plan Program (MSPP) pursuant to the Patient Protection and Affordable Care Act (ACA). The ACA will bring about a new paradigm by extending health care coverage and benefits to millions of individuals who are currently uninsured. The Affordable Insurance Exchanges (Exchanges) are intended to be vital components in fulfilling the ACA's promise to make high-quality health care available to all Americans. Multi-state plans (MSPs) will be among the several private health insurance options offered on the Exchanges beginning in 2014.

The AMA is hopeful that the Exchanges will lead to greater consumer protections for patients and provide them with more health insurance options tailored to meet their needs. However, in order to accomplish this, all insurance participants need to be playing by the same rules to prevent adverse selection and competitive advantages. OPM acknowledges, in the Preamble to the proposed rule, that "…the MSPP is an important tool for implementing the Affordable Care Act by fostering competition in Exchanges on the basis of price, quality, and benefit delivery, while ensuring that MSPs operate on a level playing field with other issuers operating in the Exchanges." However, we are concerned that OPM's proposed rule would provide multi-state plans too much latitude and potentially undermine the patient and physician protections established under the ACA's rules governing Exchanges and state law. We do not believe that the proposed rule ensures a level playing field between MSPs and non-MSPP plans, contrary to OPM's professed goals. Our comments below address our specific concerns.

<u>Compliance with Federal Law and State Law/Level Playing Field</u>

In most states, current laws include provisions that improve the health insurance marketplace for patients and physicians by reining in health insurance issuer abuses. If states are to meet the

health insurance marketplace goals advanced by the ACA, then these state-level protections must be met by both single-state and multi-state plans offered through the Exchanges. These current state protections, including prompt payment of claims, fair claims payment requirements, market conduct, fair trade practices, network adequacy, consumer protection standards, grievance and appeals processes, rate review, and fraud prevention, are all vital to maintaining a health insurance marketplace focused on important patient and physician needs.

We believe that it would violate both the letter and the spirit of the ACA for multi-state plans to undermine patient and physician protections by being subject to different standards than non-multi-state plans. While we understand that some national health insurers have expressed concern about the challenges posed by having to comply with the laws of various states, the AMA has done an in-depth evaluation of this issue and has determined that, with minimal exceptions, it is possible for a health insurance issuer to comply with the managed care reform laws and regulations of all 50 states.

Furthermore, we believe that OPM can help ensure that MSPs provide protections for patients and physicians through adopting the AMA's "National Managed Care Contract." If adopted by a health insurance issuer, this contract would enable the health insurance issuer to use a single contract with physicians in all 50 states and still comply with all state law requirements. Accordingly, there is no practical hurdle to a multi-state plan's ability to comply with a subset of these states' laws.

Moreover, section 1324 of the ACA requires a level playing field with respect to laws regulating private insurance issuers. This section requires that alternatives to private insurance, including multi-state plans, be subject to certain federal and state laws that also apply to private health insurers. These laws govern the following areas: guaranteed renewal; rating; preexisting conditions; nondiscrimination; quality improvement and reporting; fraud and abuse; solvency and financial requirements; market conduct; prompt payment; appeals and grievances; privacy and confidentiality; licensure; and benefit plan material or information. As the National Association of Insurance Commissioners (NAIC) pointed out in its August 10, 2011 letter in response to OPM's Request for Information, there is a strong possibility of unlevel playing fields occurring in Exchanges if multi-state plans are not required to follow federal or state requirements regarding these patient and physician protections. If multi-state plans are exempt from such consumer protection laws and regulations, other plans within Exchanges that are subject to different regulatory standards would be competing against the multi-state plans; if the standards are more stringent for the non-multi-state plans, multi-state plans could have an unfair competitive advantage.

In addition, if multi-state plans are not subject to federal and state protections, then under section 1324, it could have the unintended result of all private health insurance issuers being exempt as well. Ultimately, this has the potential to undermine the health insurance market reforms and gains in patient protections and benefits that are key elements of the ACA. **Therefore, we urge OPM to require that any MSP with which it contracts be subject to the same patient and physician protections to which private health insurance plans are subject. Multi-state plans should be required to follow patient consumer protection laws in the state where the patient resides. Since the multi-state plans will be deemed certified as qualified health plans for purposes of participating in Exchanges, this action by OPM is very important.**

Network Adequacy

A critical attribute of health care coverage is the network of contracted physicians and other health care providers. For financial reasons, patients are most likely to obtain medical care from physicians and other health care providers who have contracted with a provider network to which the patient has a right of access. A provider network that does not have an adequate number of contracted physicians and other health care providers in each specialty and geographic region deprives patients of the full benefits for which they have paid.

Inadequate provider networks also undermine public health and welfare by forcing patients to reduce utilization of appropriate preventive services and to fail to obtain necessary medical care. This in turn leads to reduced productivity and increased work absenteeism, unnecessary illness, and increased emergency department utilization. To assess the appropriateness of a provider network before selecting a particular health insurance plan, patients must have all the information relevant to the medical needs of themselves and their families, including: (1) whether their physicians and preferred hospitals are in or out-of-network; (2) whether these physicians and hospitals are still accepting new patients; and (3) what the likely wait-time is for an appointment. Patients also need access to a robust, up-to-date provider directory to enable them to determine which physicians, other health care professionals, and health facilities remain in the network as their medical needs change. An important component of an up-to-date provider directory includes ensuring patients know the education and training of the physicians and other health care professionals within the network. This can be accomplished easily by including the full title of the relevant licensure description of the provider (e.g., medical doctor, nurse practitioner, physical therapist, etc.). Further, qualified health plans (QHPs) and multi-state plans should disclose their networks for patients during the enrollment process, so that patients can access them prior to purchasing a policy.

We are concerned that OPM's proposed approach to network adequacy, while intended to mirror the standards that would apply under Exchanges to non-MSPs, is too broad and leaves too much discretion to OPM to determine the adequacy of a provider network. OPM should defer to state standards in this critical area. To ensure an adequate provider network for multi-state plans, the AMA calls for certification by the state department of insurance of the plan's provider network. States should establish a similar procedure for QHPs and multi-state plans in the Exchanges. The AMA has prepared model legislation—the "Meaningful Access to Physicians and other Health Care Providers: Network Standards Act"—to assist states in developing a thorough certification process. The model language calls on plans to disclose the geographic and population capacity of the provider network. The provider network certification should be awarded only to the extent that the provider network offers the access to physicians and other health care providers reasonably necessary to ensure that all enrollees of a health insurance issuer product using the provider network will have timely access to all the medical care that they need on an in-network basis, including but not limited to, access to emergency services 24 hours a day, seven days per week. **We urge OPM to require that all MSPs comply with state network adequacy requirements, and we will continue to share our model network adequacy language with states to assist them as they strengthen their requirements.**

Medical Loss Ratio

OPM proposes to require an MSPP issuer to attain the Medical Loss Ratio (MLR) required under section 2718 of the Public Health Service Act. However, OPM reserves to itself the authority to impose a different, MSP-specific MLR threshold if that "would be in the best interest of enrollees." We are concerned that this discretion is too vague and potentially sets up an unlevel playing field with non-MSP plans that would be subject to different MLR requirements, thereby undermining the ACA's important goal of transparency for insurance plans.

As noted by the Commonwealth Fund and others, a strong MLR helps ensure that health insurers direct premiums toward medical care and not administrative costs. The AMA urges OPM to support a strong MLR standard, and to avoid broadening this standard to allow health insurers to include any administrative or cost containment related expenses in the ratio determination. We strongly support the final medical loss ratio requirements adopted by HHS for Exchanges, which already has saved patients $1.5 billion. These final standards rigorously protect patient premium dollars for direct patient benefit use only. The AMA worked closely with NAIC, consumer, and insurer representatives in developing these recommendations. **We urge the OPM to retain these strong standards, and not allow any flexibility or reduced patient protections for multi-state plans.**

Thank you for considering our comments, and if you need further information, please contact Margaret Garikes, Director of Federal Affairs at margaret.garikes@ama-assn.org or (202) 789-7409.

Sincerely,

James L. Madara, MD