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Statewide Parent Advocacy Network, Inc.
Empowered Families: Educated, Engaged, Effective!

Family Voices-NJ Comments on the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act
Submitted Sept. 13, 2010

Thank you for the opportunity to comment on preventive services under the Patient Protection and Affordable Care Act. Family Voices is a national network that advocates on behalf of children with special healthcare needs and works to "keep families at the center of children's healthcare." Our NJ Chapter is housed at the Statewide Parent Advocacy Network (SPAN), NJ's federally designated Parent Training and Information Center, Family-to-Family Health Information Center, and chapter of the Federation of Families for Children's Mental Health. The NJ Coordinator also serves in a voluntary capacity as the NJ Caregiver Community Action Network representative for the National Family Caregivers Association for caregivers across the lifespan, as well as volunteering for the local and state chapter of the National Alliance on Mental Illness.

Supplementary Information

I. Background

We strongly support the definition of "group health plan" inclusive of both insured and self-insured plans under ERISA. We also agree that the Affordable Care Act requirements can not be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of the Affordable Care Act.

II. Overview of the Regulations:

We strongly support the coverage of preventive health services, particularly with the prohibition of cost-sharing requirements. We support the use of evidence based services using the current recommendations of the U.S. Preventive Services Task Force. We support the recommendations on immunizations and the concept of reducing vaccine-preventable disease. We strongly support the screenings for children. These items will be discussed in detail later in the document.

We are concerned however that billing of preventive services is subject to certain conditions. First, "if the recommended preventive service is billed separately…then a plan…may impose cost-sharing requirements to the office visit." Clarification is needed on this because all plans would need to do is just bill separately and patients would still have cost-sharing. "Second, if the …service is not billed separately…and the primary purpose of the office visit is the delivery of such…service, then a plan…may not impose cost-sharing…." We agree with this because it should be if the primary purpose of the visit is wellness, then there should be no cost-share, rather than basing it on business practices. "Finally, if a…services is not billed separately…and the primary purpose of the office visit is not the delivery of such…service, then a plan…may impose cost-sharing." We do not agree that there should be cost-sharing for the preventive services, even if given during a sick visit, just for the other services. Lastly, we agree that for services that are out-of-network, there can be cost-sharing. However, this should only be imposed if the plans have adequate in-network providers and not because of network inadequacy.

We also agree that if the "guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan…can use reasonable medical management techniques to determine any coverage limitations". However, we would suggest national standardization whenever possible or monitoring including tracking and sanctions of patterns of abuse of this flexibility. This is especially important because patients and parents of child patients are generally not aware of reasonable and appropriate methods, treatments or settings for the provision of preventive services; without national standardization or close monitoring, patients and parents of patients will be at a significant disadvantage regarding whether or not coverage limitations are reasonable.

We strongly support that the "regulations clarify that a plan…continues to have the option to cover preventive services in addition to those required…" Many plans currently cover wellness initiatives. We agree that for these additions, the plan *may* impose cost-sharing where they exceed federal regulations. We also understand that plans may use cost-sharing in for "treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service."

We support the provision that for plan years beginning on September 23, 2010 that any new recommendations added to the guidelines take effect "one year after the date the recommendation…is issued." This way the www.healthcare.gov prevention section can be updated on an ongoing basis. We also agree that plans should not have to cover services that "ceased to be a recommended preventive service." However, plans should not be able to retroactively bill if patients were originally told there was no cost share for that service. We also agree that other requirements under state or federal law may apply. For example, we support that plans must give "60 days advance notice to an enrollee before any material modification will be effective" under the PHS Act. We disagree that "recommended preventive services without any cost-sharing requirements do not apply to grandfathered health plans." This will not be cost effective and research indicates will result in poorer health outcomes.

III. Interim Final Regulations and Request for Comments

We strongly agree with the Departments' determination that "it is impracticable and contrary to the public interest to engage in full notice and comment rulemaking before putting these regulations into effect, and that it is in the public interest to promulgate interim final regulations." However, we encourage widespread notice of the interim final regulations as soon as practicable and development of a process that allows for robust public input, including regional opportunities to hear concerns and recommendations from families and individuals.

IV. Economic Impact and Paperwork Burden

We agree that this regulation is "economically significant" (…annual effect on the economy of $100 million in any one year)".

A. The Need for Federal Regulatory Action

We agree that there is underutilization of preventive services due to plans not having incentives to cover preventive services, that benefits are not immediately apparent, and that the benefits "accrue to society as a whole, and …do not get factored into an individual's decision-making…", but we do know families have had to forgo preventive care because they also couldn't afford it. We also agree that these issues are addressed by requiring non-grandfathered plans in both the group and individual market to participate, eliminating the lack of incentive, and by eliminating family cost-sharing.

B. Coverage of Preventive Health Services

1. Summary

As stated earlier, we support evidence based services, immunizations, and screenings for women and children.

2. Preventive Services

We agree with the use of the recommendations of the Task Force and Advisory Committee and current HRSA guidelines.

3. Estimated Number of Affected Individuals

We agree with the definition of large plans as covering 100 or more individuals, and small group plans as less than 100. We agree with the current estimates of 72,000 ERISA plans and 2.8 million small group plans (97 million in large plans, 40.9 million in small plans); 126,000 governmental plans (36.1 million in large and 2.3 million in small plans); and 16.7 million under age 65 in individual plans. As stated earlier, we disagree that grandfathered health plans will be exempt. We also feel that the mid-range estimate of regarding 66% of small and 45% of large plans relinquishing status before

the changes in 2014 is too high. We do agree that the numbers for the individual market will be higher than the group market. However, 40% relinquishment of status for individual plans still seems high. The current mid-range estimates are 98 million in grandfathered group plans and 10 million in individual non-grandfathered plans. We also know that state law (e.g. immunization required in 29 states) will also affect these numbers. Thus we agree with the uncertainty in final numbers because it will be affected by grandfathered status, what state benefits are, and if plans voluntarily offer preventive coverage.

4. Benefits

We strongly agree that the benefits will be better health outcomes (including avoidable hospitalization), increased worker productivity (less absenteeism), cost savings, and equitable distribution of preventive care. The cost savings would also affect Medicaid and Medicare. We agree that preventive measures can help ameliorate the estimated $260 billion annual lost labor time. We also agree that obesity, which can also be addressed by preventive measures, increases absenteeism. We understand that the Task Force examined health outcomes as well as "that benefits outweigh harms…" We agree that research shows improving 5 preventive services will "avert 100,000 deaths per year". Other research showed by increasing the utilization rate to 90% for 8 services would save 150,000 lives. However, we agree that the average increase will be moderate ("5-10 percentage points") for some. We also strongly support that some services have "both individual and public health value" such as immunizations. Further, it will also protect those "who cannot receive the vaccine…against the disease… indirectly protected." Personally, I am the parent of a medically fragile child for whom, although she's in the high risk group and even gets extra immunizations, there are some that are contraindicated due to her health condition. We also understand that for every dollar spent on immunization, $5.30 is saved on healthcare. Overall, there will be only a small increase in premiums, offset by larger savings in out-of-pocket costs.

5. Costs and Transfers

We strongly agree that there will be increased utilization of preventive care. It was unfortunate that the research showed a 1% increase in out-of-pocket costs for immunizations resulted in a .07% decrease in utilization, so the regulations will help this.

a. Estimate of Average Changes in Health Insurance Premiums

We agree with the Department's estimate that administrative costs will increase in proportion to the benefits and that the increases in benefits will result in higher premiums. The Department further examined the changes in cost-sharing, services covered, and increased utilization of preventive care. We agree it is difficult to estimate because there is no baseline data on preventive services and if there will be additional utilization due to reduced cost-share. The example is given that the average preventive benefit will increase by $24 (.6% increase for premiums but with a larger effect on individual plans). Although we were surprised that the example BC/BS standard option

“average” plan did not cover certain genetic testing, depression screening, lead, autism screening, and oral health”, it was estimated that adding them results in .12% increase in benefits, or $4 per person. Another estimate showed increased utilization due to decreased cost sharing resulting in an increase of benefits by $17 or .44% in group plans (higher in individual plans). The Department calculated the average impact that premiums will increase as 1.5% for enrollees in non-grandfathered plans.

b. Sensitivity analysis

We appreciate that the Departments looked at smaller and larger addition in benefits, $2 and $6 respectively. The Departments also examined if the behavioral change (i.e. increased utilization due to decreased cost share) were 15% smaller or 15% larger. Again, the estimate was that these changes would be larger in the individual vs. group market. The low end estimate was a few tenths of percent, mid range was 1.5%, and high end just a few tenths of a percent higher than that. We are concerned with premium increases and hope that the mid-range estimate is accurate.

6. Alternatives Considered

We agree that “cost sharing should be prohibited only when the preventive service is the primary purpose of the office visit” however we feel that if preventive care is made during a “sick” visit, that service should be exempt. We are also concerned that “if the preventive service is billed separately form the office visit, it is the preventive service that has cost sharing waived, not the entire office visit” is too broad and will be misinterpreted to mean that the billing mechanism itself determines cost-sharing, rather than the type of service. We do agree that out-of-network preventive services should have cost sharing but again add only if there is adequate in-network coverage.

C. Regulatory Flexibility Act-Department of Labor and Department of Health and Human Services

We agree that because the Department “made a good cause finding that a general notice of proposed rulemaking is not necessary” they are not required to “either certify that the regulations would not have a significant impact on a substantial number of small entities or conduct a regulatory flexibility analysis.” Although we do feel that there will be a likely impact on small entities, we do not have any suggestions at this time on minimizing this impact.

D. Special Analysis – Department of the Treasury

We agree that “this Treasury decision is not a significant regulatory action” and that therefore “a regulatory assessment is not required.”

E. Paperwork Reduction Act

We agree that these regulations "are not subject to the requirements of the Paperwork Reduction Act…because it does not contain a 'collection of information'…"

F. Congressional Review Act

We agree that these interim final regulations are "subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act".

G. Unfunded Mandates Reform Act

We agree that these rules are not subject to the Unfunded Mandates Reform Act because they are being issued as interim final regulations.

H. Federalism Statement

We agree these rules have federalism implications because it directly affects "States, the relationship between the national government and the States, or on the distribution of power and responsibilities among various levels of government". However this is mitigated by the fact that most states "will enact laws or take other appropriate action resulting in their meeting or exceeding the Federal standard."

V. Recommended Preventive Services

We are also commenting on the supplemental materials.

A. Recommendations of the United States Preventive Services Task Force

We have examined the complete list of USPSTF Grade A and B Recommendations as comprehensive and will be commenting on those that affect children. We strongly support interventions to encourage breast feeding as research indicates better health outcomes for children. We agree with the recommendation on dental caries for children older than 6 months but would caution that fluoride supplementation may be contraindicated for certain health conditions such as kidney disease. We highly support adolescent screening for depression and would recommend the use of the tool "Teen Screen" which has been proven cost effective as well as resulting in better health outcomes as a preventive measure. We highly support supplementation of folic acid for pregnant women as research indicates that this reduces birth defects such as spina bifida. We agree with prophylactic eye drops for newborns against gonorrhea effects. We strongly support newborn hearing screening and have been involved with the NJ Early Hearing and Detection Intervention program. We also support Hep B screenings for pregnant women to protect the baby from developing life-long chronic infections. We also agree with iron supplementation for children 6-12 mos. who are at risk of anemia and would like to add screening for adolescent girls once they start menstruation. Although we support obesity screening for children, we feel that age 6 is too old to start. Research shows that 1 in 3 children are obese, and they are already obese by at age 5. Waiting until the child is obese is not proactive or preventive. We would recommend the

AAP guidelines of measuring BMI starting at age 2. Lastly, we agree with vision screening for children under age 5. In addition, we would recommend that preventive services should be cross referenced with the Medicaid recommendations for children under Early Periodic Screening Diagnostic and Treatment requirements.

B. Recommendations of the Advisory Committee on Immunizations Practices That Have Been Adopted by the Director of the Centers for Disease Control and Prevention

We have examined the recommended immunization schedules and will comment on those affecting children. We strongly agree with the immunization schedules from birth to 6, 7 to 18, and the "catch-up" schedule. These CDC guidelines were endorsed by both the AAP and AAFP. We would also recommend the AAP article against the "alternate vaccine schedule" found at http://pediatrics.aappublications.org/cgi/content/full/123/1/e164 to ally parent concerns and increase immunization rates.

C. Comprehensive Guidelines Supported by the Health Resources and Services Administration for Infants, Children, and Adolescents

We have also examined the Bright Futures recommendations as well as the newborn screening recommendations. We strongly support all of the preventive measures in Bright Futures, which have been endorsed by the AAP. When the Bright Futures family guidelines were being developed, Family Voices NJ held parent focus groups and was the only state to hold them in Spanish as well. When the pocket guides were being revised, we were the first state nationally to hold focus groups and ours were again bilingual. Preventive health is not only cost effective but more importantly results in better health outcomes. Particularly for children, wellness initiatives such as immunizations and lead screening are especially important. We also strongly support the newborn screening recommendations and we are currently active on the NY Mid Atlantic Consortium on newborn screening.

As the Family to Family Health Information Center in NJ, we work with families and professionals to help them collaborate to improve health care access and quality for children, especially children with special healthcare needs. Thank you again for the opportunity to comment on preventive services under PPACA.

Sincerely,

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Our Mission: To empower families and inform and involve professionals and other individuals interested in the healthy development and educational rights of children, to enable all children to become fully participating and contributing members of our communities and society.