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September 17, 2010

The Honorable Kathleen Sebelius
Secretary

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Hilda Solis
Secretary

U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

The Honorable Timothy Geithner
Secretary

U.S. Department of the Treasury
1500 Pennsylvania Ave, NW
Washington, DC 20220

Dear Secretaries Sebelius, Solis, and Geithner:

The American Academy of Pediatrics (AAP), a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, appreciates this opportunity to comment on the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under Section 2713 of the Patient Protection and Affordable Care Act (ACA), as published in the *Federal Register* on July 19, 2010.

The Interim Final Rules state clearly that all private health plans must cover, without cost-sharing, all services described in *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, 3rd edition*. This valuable step forward guarantees access to comprehensive preventive health services for all children. As the Departments move toward development of a Final Rule, the AAP urges you to give special consideration to several important issues, including:

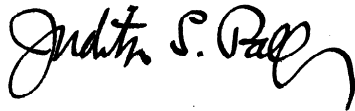
- Implications of inadequate payment or inappropriate bundling for access to preventive health services;
- The minimal impact of pediatric preventive care coverage on insurance premiums;
- Timely adoption of updates to *Bright Futures*;

- Application of Section 2713 to the Medicaid program;
- Access to preventive care services under grandfathered plans;
- Implications of cost-sharing for conditions identified through preventive care;
- Enforcement and compliance issues;
- Support for the delivery of preventive care in the medical home; and
- Incorporation of *Bright Futures* guidelines into electronic medical records.

Each of these issues must be addressed if the ACA's preventive care services provisions are to reach their full potential in improving the health of Americans. The Interim Final Rules also have important points of interaction or overlap with other regulations under development or currently open for comment; the AAP urges the close examination of the interaction of these proposals.

The attached letter describes these issues in more detail. We look forward to working closely with you to ensure that these regulations support patient and family health and pediatric providers' ability to serve our nation's children and youth. If the AAP can provide further assistance, please do not hesitate to contact Cindy Pellegrini or Robert Hall in our Washington, DC office at 202/347-8600 or cpellegrini@aap.org/rhall@aap.org.

Sincerely,

A handwritten signature in black ink that reads "Judith S. Palfrey". The signature is written in a cursive, flowing style.

Judith S. Palfrey, MD FAAP
President

The American Academy of Pediatrics (AAP) appreciates the opportunity to comment on Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under Section 2713 of the Patient Protection and Affordable Care Act (ACA), as published in the *Federal Register* on July 19, 2010. These rules take important steps toward ensuring that all children will have access to vital preventive medical care, including the full menu of services recommended by the AAP and Health Resources and Services Administration (HRSA) in *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*, 3rd edition.

While the Interim Final Rules contain many commendable provisions, the inclusion of several other items would further strengthen the regulations. As the Departments consider refinements to the Interim Final Rules in preparation for issuing Final Rules, the AAP urges you to address the following issues to ensure that all children have access to comprehensive preventive health care as soon as possible.

Inadequate payment or inappropriate bundling could limit access to preventive health services.

The AAP was deeply disappointed that the Interim Final Rules failed to address in any way our pressing concerns surrounding payment and bundling for preventive care. In order to be effective, preventive health care must be *valued*, meaning that its priority must be reflected in payment rates.

Copayments are often charged for well child and adolescent visits. Thus, the practitioner's reimbursement is the sum of the family's copayment and the insurance company's reimbursement. In addition, insurers frequently "bundle" well child visits and services as part of other pediatric care, or simply refuse to pay for these services by ignoring Current Procedural Terminology (CPT) guidelines.

If the Final Rule allows insurers simply to eliminate copayments without paying in full for the preventive services and screenings delivered at a visit according to the *Bright Futures* guidelines, reimbursement will be inadequate and thus create a disincentive to provide these important services. This unintended consequence could cause children to receive fewer well child visits and decrease access to medical home services. The connection between adequate provider payments and access to services is well documented.^{1,2,3} "Bundling" rewards practitioners for providing less health screening and penalizes practitioners providing complete *Bright Futures* screening and preventive services. Failing to address this issue could undermine both the letter and spirit of Section 2713.

Beyond the impact on children's access to preventive services, losing the revenue stream from copayments could be devastating to pediatric practices. For almost all pediatric practices, well baby/well child copayments paid with the caregiver's funds represent a key revenue stream. For office-based pediatricians, co-payments account for an estimated 8.6% of total preventive care service payment and 2.5% of all payment on behalf of privately insured patients, according to the 2005 Medstat MarketScan database.

Data from the 2008 AAP Socioeconomic Survey of Pediatric Practices suggests that copayments for preventive services in the average pediatric practice represent an estimated 1.5% of total pediatric practice revenue, the equivalent of an average of \$8,200 annually for each full-time equivalent pediatrician.^{4,5} In a practice with multiple physicians, copayments account for a substantial percentage of cash flow. With many pediatric practices already in precarious financial circumstances due to the low payments provided by public and private insurers, this additional burden could make the difference in their viability. Pediatricians throughout the country report that private insurers commonly ignore and fail to reimburse for established CPT codes for many pediatric services, including immunization administration, developmental and autism screening, and hearing and vision screening. Combined with generally dismal Medicaid payment rates, these burdens could make it impossible for many pediatric practices to absorb a loss in payment from the shifting of the cost-sharing revenue stream to a cost to the pediatric practice. The Final Rules should require that payers' reimbursement levels to physicians and other health care providers be adjusted to reflect the loss of copayments.

A handful of reports from AAP chapters indicate that some insurers are in fact not shifting the expense of eliminating cost-sharing to physicians, but are incorporating those sums into their payments to providers. The AAP has received indications that physicians participating in certain plans have already received revised contracts notifying that the patient copayment will be assumed by the insurer, holding the physician harmless.⁶ The Final Rules should affirm this as the correct method of compliance and make such best practices available to insurance companies as models.

The AAP is also concerned that the Interim Final Rules do not bar payers from engaging in inappropriate bundling of certain services, or the elimination of separate payments that currently exist for some services recommended in *Bright Futures*. If increasing numbers of services are bundled into the health supervision visit payment without increases in that payment level, pediatricians will face an untenable mandate to do more with less. Such a development would certainly undermine the goals of the ACA in seeking to prioritize preventive health services and reward providers for high quality care, reducing services provided to children instead of increasing access.

Coverage for pediatric preventive health care will have a minimal impact on insurance premiums.

The AAP disagrees strongly with any assertion that comprehensive coverage of pediatric preventive care could result in more than minimal increases in insurance premiums. Preventive care services represent the single most effective investment we can make in the health and wellbeing of our nation's children. Preventive medical care can avert the enormous human, economic and societal costs of many forms of infectious disease, chronic illness, and injury in the pediatric population. Most chronic adult illnesses have their beginnings in childhood. Medical research has borne out the conventional wisdom that an ounce of prevention is indeed worth a pound of cure:

- Routine childhood vaccination saves nearly \$10 billion indirect medical costs and \$43 billion in societal costs for every birth cohort.⁷ The hepatitis B vaccine saves 50 cents in direct medical costs and \$3.10 in indirect costs, while the varicella vaccine (for chickenpox) saves 90 cents in direct medical costs and \$5.40 in indirect costs.⁸
- The economic value alone of the prevention of mental retardation due to just two metabolic conditions (phenylketonuria and congenital hypothyroidism) exceeds \$400 million per year, more than twice the amount of money spent on all newborn screening.^{9,10}
- Low-income children who have their first preventive dental visit by age one are not only less likely to have subsequent restorative or emergency room visits, but their average dentally-related costs are almost 40% lower (\$263 compared to \$447) over a five-year period than children who receive their first preventive visit after age one.¹¹

Questions have been raised as to whether coverage for preventive care services for children without cost-sharing will cause insurance premiums to rise. The AAP recognizes the balance that must be achieved by the Departments between affordability and coverage of services required by Section 2713. Nevertheless, the AAP would urge the Departments to value access to benefits more highly than concerns over hypothetical premium increases in the context of children's services. In particular, the AAP would question whether advocates of limiting benefits have distinguished between the costs of providing preventive health care services for children as distinct from adults.

The best available data indicate that improving access to pediatric preventive care services should have a negligible impact on insurance premiums. In its report, "The Business Case for Investing in Maternal and Child Health," the National Business Group on Health calculated average cost and actuarial value for a wide range of preventive and treatment services. The report recommends covering well child care in accordance with the *Bright Futures* guidelines and not imposing any cost-sharing associated with these services. The report concludes that:

- Providing well child care in accordance with the *Bright Futures* guidelines and periodicity schedule, without imposing cost-sharing, would cost an additional \$2.24 per member per month, or \$26.88 per year.¹²
- Providing immunizations in accordance with Advisory Committee on Immunization Practices recommendations to all children and pregnant women, without imposing cost-sharing, would add an additional cost \$2.21 per member per month, or \$26.52 per year.¹³

Given that the average cost of health insurance for a family of four is now calculated to be \$13,375,¹⁴ the cost of providing coverage for all well child care and immunizations would total \$213.60 (\$53.40 per year each for four family members), or 1.6 percent of the family's annual premium. Notably, this figure represents a "worst case" scenario for adding preventive health care benefits to a plan that currently covers none; in reality, most plans cover a substantial portion of these benefits already, meaning that little or no

change in premiums should be attributable to the Section 2713 mandate for children's services. Section 2713 was designed to provide a baseline level of pediatric preventive care services for those rare plans that do not already do so.

Additionally, it is important to note that insurance premiums for family coverage do not usually vary based on the number of children in the family. Large families are usually charged the same amount as small families for family coverage. This fact further supports the argument that preventive care costs for large numbers of children can be distributed effectively and inexpensively over the risk pool.

It should be noted that coverage for pediatric preventive care services and assumption of patient cost-sharing amounts by insurers are obvious candidates for inclusion in calculating the insurer's medical loss ratio (MLR). Counting these expenses toward the MLR should benefit insurers who might have difficulty reaching the MLR standard promulgated under the ACA.

Finally, the AAP would remind the Departments that this modest investment in pediatric preventive care can prevent staggering costs associated with treatment or hospitalization for preventable diseases, lead to early detection and treatment of chronic illness, and much more. Some may argue that future savings may not accrue to the insurer paying for preventive care due to the frequent insurance coverage churning that children experience. Churning rates in the pediatric population are high, with research showing more than 25 percent of children uninsured for part or all of a year.¹⁵ With the ACA's promise that the vast majority of citizens will be covered, however, segregating market risk is a less advantageous strategy for insurers, whose new motivation should be providing quality coverage that incentivizes healthy behaviors and the early detection and treatment of conditions. Given the tremendous societal and individual benefit of preventive care in allaying child and family suffering, a minimal increase in insurance premiums should be valued as a worthy investment.

The Final Rules should guarantee timely adoption of updates to *Bright Futures*.

Bright Futures is currently in its third edition, and periodic updates should be anticipated as new evidence on pediatric preventive care is generated. The AAP praises the Interim Final Rules for requiring plans to comply with changes to the services recommended under *Bright Futures* for plan years beginning one year after those changes are accepted by the HRSA Administrator. The regulations do not, however, set any timeline by which the HRSA Administrator must accept or reject proposed updates to *Bright Futures*. The AAP urges you to include in the regulations language stating that the HRSA Administrator must accept or reject any proposed updates to the *Bright Futures* guidelines within six months of receipt.

Section 2713 should apply to the Medicaid program.

Over 30 million children are currently covered by Medicaid programs across our nation. These children, who represent the most vulnerable individuals in our society, need and

deserve access to the full range of preventive health services set out in *Bright Futures*. While the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate would seem to require coverage of all these services, coverage varies widely across state programs. The Final Rules present an invaluable opportunity to affirm access to comprehensive preventive care for all children covered by Medicaid.

At a minimum, the Final Rules should be applied to Medicaid managed care plans. While Medicaid managed care may be financed by the government, medical care is organized, delivered, and coordinated by the private plans with which states contract. Because care is delivered by private plans, Section 2713 should apply to all Medicaid managed care contracts.

The draft HHS Strategic Plan 2010-2015 lists among its strategies for emphasizing primary and preventive care linked with community prevention services, “Remove financial barriers to accessing recommended preventive health services by providing health insurance that includes coverage of these services at no cost to the patient” and “Ensure the delivery of recommended evidence-based preventive screenings and services with no copayment, through *all public and private health plans*.” (emphasis added) It is difficult to see how meaningful progress can be made toward this goal without extending these no-copayment services to Medicaid patients.

Access to preventive care services should be improved under grandfathered plans.

The Interim Final Rules state unequivocally, “The requirements to cover recommended preventive services without any cost-sharing requirements do not apply to grandfathered health plans.” The AAP is deeply concerned that this interpretation will needlessly delay access to preventive care for millions of children. Moreover, there may be considerable confusion among families who eagerly anticipate coverage of preventive care only to find that they will not receive it because they are covered by a grandfathered plan. The Departments have received comments from the AAP on this subject on the proposed regulations regarding grandfathered plans. We urge the Departments to consider carefully the ramifications of the rules on grandfathered plans for the Interim Final Rules on Section 2713 preventive care.

Implications of cost-sharing for conditions identified through preventive care must be considered.

As the Departments move forward with the implementation of Section 2713 and other provisions of the ACA, it will be critical to consider the implications of increasing coverage of and access to preventive care services for other aspects of patient care. The AAP whole-heartedly supports the concept of providing preventive care without cost-sharing as a proven method of encouraging utilization of these services. However, given that some forms of preventive care are actually secondary and tertiary prevention – i.e., early detection rather than primary prevention – it is expected that some services will identify critical health needs that require treatment. The Administration and policymakers must consider the needs of individuals who may need treatment for the

issues identified through screenings and potential cost barriers to treatment and related services.

One effective way to address this issue would be to ensure that any treatment to address conditions identified through preventive screening is considered part of the pediatric services included in the "essential benefits" in the law. As the definition of "essential benefits" is established, it will be critical for the Departments to promote a specific review of the conditions that could be identified through preventive screenings and to ensure that appropriate treatment is included among those benefits. For pediatrics, these services would include not only hearing, vision, and oral health services (which are specified in the statute) but also treatment for developmental delays, behavioral issues, autism, infectious diseases, and more.

Enforcement and compliance issues should be clarified.

The Interim Final Rules leave vague which governmental entities will be responsible for enforcing the various parts of the Section 2713 mandate. If the traditional rubric is followed, enforcement on federally-regulated Employee Retirement Income Security Act (ERISA) plans will be undertaken by the Department of Labor, while enforcement on state-regulated group and individual plans will fall to state insurance regulators. If this will be the case for Section 2713, this fact should be made clear. Furthermore, information and resources should be provided for both health care providers and patients who have questions or wish to report potential violations.

Support should be expressed for the delivery of preventive care in the medical home.

The Interim Final Rules fail to include any language supporting delivery of pediatric preventive health care within a medical home. The ACA goes to great lengths to promote adoption of the medical home as the primary source of medical care, and the law envisions an increasing reliance on the medical home to promote good health and deliver preventive care. Research has demonstrated that the medical home can produce both cost savings and improved health outcomes, particularly for children with special health care needs.^{16,17,18} The Final Rules should not fail to take advantage of this important opportunity to stress the central role that the medical home is expected to play in preventive care delivery and health promotion. Moreover, communication within the medical home occurs face-to-face in the visit, by telephone or by electronic media. To enhance access, meet the needs of the family, and encourage care that is comprehensive and family-centered, mechanisms for reimbursing all aspects of professional services and communications should be addressed.

Incorporation of *Bright Futures* guidelines into electronic medical records should be encouraged.

Section 2713 presents a unique opportunity to integrate appropriate preventive care guidelines into electronic medical records (EMRs), health information exchange (HIE),

and personal health records (PHRs). Ambulatory EMRs are typically designed to address the needs of the adult population. Adult-oriented EMRs usually cannot be easily adapted to meet the special requirements of pediatric care. However, EMRs that support child health care will by definition meet the needs of adolescents as they transition to adult care, which makes them useful for all ages. Recognizing the priority that Section 2713 places on preventive care, all EMRs designed for use with children and adolescents should include *Bright Futures*. Requiring these EMRs to include or access *Bright Futures* in order to meet both the Medicare and Medicaid “Meaningful Use” standard for 2013 would also greatly improve efforts to measure quality and support research. The AAP strongly recommends that you instruct the Office of the National Coordinator to incorporate the Bright Future principles in the Quality Measures for the 2013 Meaningful Use criteria.

The Interim Final Rules incorporated a number of issues that the AAP had recommended be addressed as part of these regulations. The AAP appreciates the inclusion of the following provisions and urges strongly that they be retained in the final rule.

Affirmation of *Bright Futures* as the standard for required pediatric preventive services. The Interim Final Rules make abundantly clear that the statutory mandate for insurers to cover, “With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration,” is a reference to the *Bright Futures Guidelines*. The inclusion of the *Bright Futures* periodicity schedule in the regulation and on the website for insurers further affirms this fact, eliminating any potential ambiguity for insurers, physicians, or families. The use of *Bright Futures* as the standard for pediatric preventive health care will ensure that all children have access to a full range of services, including immunization administration, health supervision, and anticipatory guidance, in accordance with the well child care periodicity schedule, free of financial barriers.

Statement that *Bright Futures* services must be covered by all private health plans. The Interim Final Rules make clear that all private insurance plans must cover *Bright Futures* services, including group plans regulated under ERISA, group and individual plans regulated by states and the federal government under the Public Health Service Act, and coverage provided to state and local government employees.

Definition of cost-sharing. The AAP appreciates the comprehensive definition of prohibited cost-sharing under the regulation, which states that insurers “may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible)”. This definition lists the most common forms of cost-sharing but is not exclusive, meaning that other forms of cost-sharing could also be included in this definition should they be imposed.

In conclusion, the American Academy of Pediatrics appreciates this opportunity to offer 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. If the Academy may provide additional assistance, please contact Cindy Pellegrini or Robert Hall in our Washington, DC office at 202/347-8600. We look forward to working with you to using the ACA to improve the health of all our nation's children.

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