



AMERICAN ACADEMY of ACTUARIES

Sept. 17, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIO-9992-IFC
P.O. Box 8016
Baltimore, MD 21244

Re: Interim Final Rules Relating to Coverage of Preventive Services

To Whom It May Concern:

On behalf of the American Academy of Actuaries'¹ Benefits and Eligibility Work Group, I appreciate the opportunity to provide comments to the Departments of Health and Human Services, Treasury, and Labor on the interim final regulation (IFR) on the coverage of preventive services. This rule would implement new Section 2713 of the *Public Health Services Act*, as adopted in the *Patient Protection and Affordable Care Act*, which requires non-grandfathered health plans and health insurance contracts to cover a variety of preventive services no cost sharing.

Our comments fall into two categories: coverage issues and economic impact.

Coverage Issues

The list of recommended preventive services to be covered without cost sharing includes recommended services that have received an A or B rating from the United States Preventive Task Force. These preventive care guidelines were drafted initially by clinicians as recommendations to other clinicians and not as determinants of health care coverage. Without clarification or delineation on coverage frequency and/or what is covered/not covered, there may be multiple interpretations between insurers/administrators and consumers/providers—with respect to when and what services are covered at 100 percent. The latter may be the most expansive in cost because consumers and providers may tend to use more liberal interpretations of services covered at 100 percent.

As noted, the ambiguity in the interim final rule could lead to multiple interpretations, specifically with respect to what is covered. One interpretation is that a screening or referral visit (e.g., an office visit that resulted in a recommendation for genetic testing or obesity counseling and behavioral intervention) would be the covered events, rather than the actual counseling, testing, behavioral interventions.

¹ The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

The two disparate interpretations lead to significantly different cost implications. If follow-up treatment is included, then the number of counseling visits and annual service schedules should be specified, and test results should be studied at the end of a treatment to evaluate the health outcomes. If the frequency of a covered treatment is not specified, the number of services could continue indefinitely and, as a result, costs could increase, since there would be no clarity on an acceptable length of treatment or a step-therapy protocol. This concern could be mitigated by a recommendation that the physician issue annual referrals after preventive visits and assess the need for additional treatment annually.

Screening for hypertension is one example of how ambiguity can lead to different interpretations. Once a hypertensive patient is diagnosed, future visits are no longer simply screening for blood pressure. Consumers and providers, however, may continue to consider future screenings as preventive and not subject to cost sharing. If a patient is screened for, but not diagnosed as, hypertensive, however, additional clarification is needed on the frequency of future screenings and what constitutes preventive coverage.

Another example would be immunization that is recommended for health care personnel. Many, if not most, health care employers provide and may be required to provide certain vaccinations. Does PPACA preempt OSHA or other standards, with the associated cost shift to insurers?

There is also a general concern that as preventive-service lists are revised annually, adding additional tests could result in scope creep and lead to high costs for many plans that already are providing comprehensive benefits. For example, pharmacy coverage is included as part of the preventive service guidelines. Coverage of preventive aspirin therapy would now move over-the-counter drugs to the list of covered preventive pharmaceuticals. Without cost sharing, indefinite coverage of these, as well as supplemental drugs such as folic acid and iron supplementation, would add to additional coverage and costs. The general ambiguity in these guidelines, and subsequent disparate interpretations and applications of the rule, could result in misunderstandings and potentially expensive appeals. These appeals would add to overall system costs due to additional administration and litigation expenses.

With respect to group health plans, the IFR includes the statement that “if a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques to determine any coverage limitations.” (Federal Register, July 19, pp. 41728-29) This general statement, while allowing flexibility, could lead to differences in application across plans and varied financial implications.

Finally, several examples are given in the regulations as to the application of cost sharing during visits to the in-network health care provider. Since a single visit can cover preventive and other services, these examples are indicative of the administrative issues the insurer and provider will face under the new rules. The coding of the services may not change, but the claim submitted to the plans would need to indicate whether the cost-sharing amount is collected. These issues likely would lead to changes in systems, as well as billing mechanisms for the carrier and the providers.

Economic Impact

The IFR identifies cost increases associated with the inclusion of mandatory preventive services without cost sharing into the essential benefits of a non-grandfathered health insurance plan. The elimination of cost sharing will increase costs in two direct ways: (i) the cost share that no longer will be collected likely will be borne through an increase in premiums and (ii) the absence of a cost share will result in an increase in utilization, again borne through an increase in premiums. We recognize that one of the reasons for encouraging the utilization of preventive services is based on the assumption that the increased utilization will result in a net long-term reduction in medical claims, which would manifest itself in the form of lower future medical trend rates.

As identified above, there are a number of components of preventive services that have yet to be defined or are left to the health insurer to define. We cannot, therefore, predict the extent to which these services, once defined, will further affect the overall cost impact of preventive services.

In addition, we have identified other unintended consequences that may result from the elimination of cost sharing for preventive services. In general, we would define these as “behavioral changes and adaptations” that reasonably could be expected to occur as a consequence of the new requirements.

It is unclear the extent to which any or all of these were considered when the cost impact was calculated by HHS. A summary of the behavioral changes and adaptations that we have identified are as follows:

- **Overtreating**—Many health specialists assert that certain interventions engender better health by preventing or mitigating disease. Two examples are: (i) pharmaceuticals that are promoted as having therapeutic value prior to the onset of any symptoms with the intention of precluding future symptoms; and (ii) therapy sessions to treat mental health and anxiety disorders, which are promoted as favorable to general overall health and having a positive impact on the prevention of future illness. There are many more scenarios, and as such, the definition of “preventive” services could expand (i.e., “creep”) until it represents a larger proportion of health care services than is defined today. In other words, over time, the list of A- and/or B-rated services in the recommendations by the United States Preventive Task Force either will expand, and thus the list could become merely a “minimum compliance” standard.
- **Cost shifting**—Given that preventive services will be provided at no cost to the insured, reporting at the point of service may lead to coding services rendered as preventive that heretofore would not have been coded in that manner. The cost impact is anticipated to be material and measurable.
- **Spikes in number of providers, accessibility, and prices**—Demand for preventive services will increase and therefore the number of providers could increase as well. Services will become more accessible. Finally, because services will be free of charge to the insured member, downward price pressure will be mitigated. As such, there likely will be an initial increase in the number of providers, access to services, and premiums.

In addition, specific attention should be focused and the cost impact measured of the new preventive services mandates on the following:

- High deductible plans—In the group market, high-deductible plans generally provide for some type of preventive services prior to an insured having to satisfy the deductible. While there still may be some cost sharing, the effect on premiums probably will be minimal for these types of policies. In the individual market, however, it can be common to require satisfaction of the deductible prior to receiving any benefits under the policy, including preventive benefits. Requiring first-dollar coverage of preventive benefits for these types of high deductible health plans will result in material increases in premiums.
- Administrative costs—The IFR creates the requirement to identify and separate services deemed to be preventive from those that are not. Given the ambiguities identified in our “Coverage Issues” discussion above, we expect that the volume and complexity of administration will increase. On a case-by-case basis, human intervention may be required for claims adjudication. For example, as illustrated in the IFR, an office visit may include some services that are for preventive purposes and others that are associated with symptoms. The question arises from this: how is the claim to be adjudicated? The complexity and cost of adjudicating that visit may be higher than it would have been prior to the passage of PPACA.
- Misunderstandings leading to costly appeals—In addition to higher administrative costs, the complexity and ambiguity reasonably might be expected to lead to misunderstandings among providers, patients, and insurers and an associated increase in claims appeals. The cost of this increase in appeals is anticipated to be material and measurable.

Another category of cost increase that we would like to see identified and measured relates to what we refer to as “type II malpractice”—not malpractice from a legal definition but rather a set of behaviors that results in increased costs through higher utilization of services that may not be necessary. The cost implications of such additional care likely have not been reflected in the IFR analysis. The mandate to cover preventive services at 100 percent likely will lead to an increase in the utilization of preventive services. With an increase in the utilization of these services, there will be a corresponding increase in the treatment of medical concerns identified during the course of those preventive services. One would expect that the majority of this additional treatment would be beneficial to the patient, but that may not be the case in all such instances. There is evidence that indicates more patient tests and procedures than necessary are ordered to protect doctors from the potential for liability claims.²

Finally, it would be useful to have additional discussion on the long-term cost impact of the elimination of cost sharing for preventive services. The IFR indicates that these services would have the effect of increasing immediate costs. What is not clear is that when the cost impacts that were reported in the IFR were measured, at what future point were preventive services assumed

² Preidt, Robert. “Most U.S. Physicians Practicing ‘Defensive Medicine,’” *Medline Plus* (a service of the U.S. National Library of Medicine and the National Institutes of Health). June 28, 2010. http://www.nlm.nih.gov/medlineplus/news/fullstory_100476.html.

to reduce future cost increases? Recognizing that there appears to be a general lack of quantitative evidence regarding the extent to which future costs could be reduced, we would appreciate the opportunity to analyze the assumptions used in the IFR to project these reductions.

We would invite the opportunity to discuss any of these items with you at your convenience. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

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