



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  
STRONG MEDICINE FOR AMERICA

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:

I am writing on behalf of the American academy of Family Physicians (AAFP), which represents more than 94,700 family physicians and medical students nationwide. Specifically, I am writing to offer our comments on the interim final rule relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act as published in the July 19, 2010, *Federal Register*.

To summarize, the interim final rule pertains to group health plans and individual health coverage relating to preventive health services and clarifies the cost-sharing requirements when a recommended preventive service is provided during an office visit. It applies to both insured and self-insured plans that begin on or after September 23, 2010. The rule utilizes the United States Preventive Services Task Force (Task Force) to establish the benefits affected (currently using a rating of A or B) as well as the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). Updates to these preventive services guidelines will be posted on a web site to ensure plans and issuers have a readily available source to access any changes to the guidelines which would have to be implemented by the next plan anniversary date. We agree with the Department of health and Human Services (HHS) regarding what plans are affected by these rules and those that are not impacted, such as grandfathered plans.

[www.aafp.org](http://www.aafp.org)

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The AAFP agrees with the suggestion that the rules will result in four types of benefits as described in the interim final rules:

- improved health as a result of reduced transmission, prevention or delayed onset and earlier treatment of disease;
- healthier workers and children will be more productive with fewer missed days of work or school;
- some of the preventive services will result in savings due to lower health care costs; and
- the cost of preventive services will be distributed more equitably.

The AAFP agrees with the presumed benefits outlined in the final interim rule.

The AAFP also acknowledges that the Departments' very detailed methodology to assess the financial impact of the interim final rule is both thorough and delineates the likely costs associated with providing this consumer protection. We understand the difficulty in making such projections with so many unknowns and we applaud HHS for attempting to define the financial impact, acknowledging the variability inherent in such assumptions. We generally agree with the financial assumptions made in both the direct costs to institute the proposed changes and the resulting projected health care savings.

The AAFP would also like to point out that there may be another unforeseen cost ramification to physicians who see patients in some of the same or similar scenarios that are presented in the interim final rule when the financial impact was considered. If a patient comes in for a preventive service visit, also called a "well" visit, typically a co-pay will not be collected. If, however, during the visit, the patient brings up something else not related to a well visit and the physician bills the insurance company, many times, the insurer/payer covers the preventive service at 100% but the problem-oriented part at something less than the full cost. If the patient knows the preventive visit may be covered without any co-sharing, he or she may knowingly or unknowingly try to get the doctor to go beyond what is typically done at well visits to avoid paying a co-pay, which could put a strain on the physician-patient relationship. Most insurance companies will have edits to "catch" this situation, but then consequently, they may turn around and pay the physician less than the negotiated fee schedule. If HHS estimates an initial increase in the number of preventive visits, we see a corresponding increase in the number of well visits including other problem-oriented services not fully reimbursed. The AAFP suggests that HHS state in the final interim rule that payers or issuers of plans that include preventive services as this rule suggests, provide explicit descriptions of both a preventive visit versus a problem-oriented service visit. We also suggest that HHS allow both a preventive service and a problem-oriented service visit be billed when that occurs. By allowing this, it provides the patient with timely provision of care for the problem and the physician the appropriate payment for handling the problem in a timely way that prevents the patient from needing to be seen at another time.

The Departments are seeking comments related to the development of value-based insurance designs that provide information and incentives for consumers that promote access to, and higher appropriate use of, value providers, treatments and services. The AAFP agrees that consumers should be provided information regarding in-network providers versus out-of-network providers as suggested in the interim final rule. However, the AAFP is concerned that many existing networks were developed, or subsequently reduced in size, based solely on cost or efficiency and, by their very nature, are a true reflection not of value-based design, but of cost considerations. Our concern is that we may see a proliferation of efficiency-based networks that will negatively impact an already strained primary care base and as a result impact our ability to provide these much needed preventive services. Accordingly, we would suggest adding language that more clearly states the Departments' meaning of value; that it is not solely a function of costs.

The AAFP would like to address the conflicts between the evidence-based recommendations of the U.S. Preventive Services Task Force (USPSTF), which the AAFP prefers, and the evidence-informed recommendations of Bright Futures. In all cases, evidence-based recommendations should have priority. In areas where the evidence is unclear, we propose the following options:

- If one entity recommends the service and the other entity does not, the recommendation with the strongest evidence-based methodology should be covered;
- If one entity either recommends for or recommends against the clinical preventive service and the other entity does not have a recommendation, then the recommendation (either for or against) should be covered;
- If one entity recommends the service and the other entity has a Level C recommendation, then the entity with the recommendation for the clinical preventive service should be covered;
- If one entity recommends the service and the other entity has an I Statement, then the service should not be included until more evidence is available.

In addition, the AAFP has discomfort that the recommendations from Bright Futures appear to be copyrighted and are accessed by linking to a non-governmental website (<http://www.brightfutures.org/>).

Even though the interim final rule does not address clinical quality improvement and performance measures, the AAFP recommends that these measures be evidence-based.

In conclusion, we appreciate the opportunity to comment on this interim final rule. We applaud HHS for expediting the comment and approval process, so these very important changes to insurance plans and patient protections are defined and implemented in a timely manner. If you or your staff has any questions about this matter, please contact Laura Schmidt at 913-906-6000, extension 4134.

Sincerely,

A handwritten signature in black ink that reads "Ted Epperly MD". The signature is written in a cursive style and is positioned below a horizontal line.

Ted D. Epperly, M.D., FAAFP  
Board Chair

TDE: ls

<sup>1</sup> Recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.

<sup>2</sup> Current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.