AMERICAN NURSES ASSOCIATION

8515 Georgia Avenue, Suite 400
Silver Spring, Maryland 20910-3492
301 628-5000 • Fax 301 628-5001
www.NursingWorld.org

Karen A. Daley, PhD, MPH, RN, FAAN
President

Marla J. Weston, PhD, RN
Chief Executive Officer

August 24, 2010

Secretary Kathleen Sebelius
c/o Office of Consumer Information & Insurance Oversight
Department of Health &Human Services
Attention: OCIIO-0004-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

Submitted electronically to http://www.regulations.gov

Re: **Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule.**
RIN 1545-BJ61, RIN 1210-AB43, RIN 0991-AB69. 75 Fed.Reg. 37188 (June 28, 2010).

Dear Secretary Sebelius;

The American Nurses Association (ANA) welcomes the opportunity to offer comments on this proposed rule. The ANA is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses, the single largest group of health care professionals in the United States. We represent RNs in all roles and practice settings, through our state and constituent member nurses associations, and organizational affiliates. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and advocating before Congress and regulatory agencies on health care issues affecting nurses and the public. Our members include Advanced Practice Registered Nurses (APRNs) such as Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs).

This interim final regulation (IFR) provides clarification on implementation of the following Patient Protections and Affordable Care Act of 2010 (ACA) provisions limiting pre-existing conditions, exclusions, lifetime and annual caps, and rescissions, as well as providing patient protections, including the choice of health care professional. The American Nurses Association would like to offer comments regarding the choice of

health care professional section in the IFR, and address patient protections regarding the annual and lifetime limits, as well as rescissions.

Section 2719A of the PHS Act, Patient Protections (26 CFR 54.9815-2719AT, 29 CFR 2590.715-2719A, 45 CFR 147.138)

The provision occasioning ANA's primary concern occurs in the Patient Protection sections of the IFR. We would like to see the "Choice of health care professional" language strengthened to protect existing practice patterns wherein pediatric and family nurse practitioners are specifically included among health care professionals who may be designated as primary care providers, and assure that that the model language for the plan issuers' notice is modified accordingly.

The language modification we are seeking is as follows, in each of the three identical provisions:

> "(2) *Designation of ~~pediatrician~~ pediatric health care professional as primary care provider* – (i) In general. If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for the designation of a participating primary care provider for a child by the participant, beneficiary, or enrollee, the plan or issuer must permit the participant, beneficiary, or enrollee to designate a physician (allopathic or osteopathic) or nurse practitioner who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant (in the individual market, primary subscriber) of the terms of the plan or health insurance coverage regarding designation of a pediatrician or nurse practitioner who specializes in pediatrics as the child's primary care provider."

Subsection (a) of each of the three iterations of the provision, "Choice of health care professional," notes generally that a plan requiring or permitting the designation of a participating primary care provider by the participant, beneficiary or enrollee must permit the designation of any participating provider available to accept the same. If an individual does not designate a primary care provider, the plan may do so on his or her behalf, until the individual designates their provider preference. This overarching provision does not distinguish among eligible primary care providers.

Paragraph (2) of the same subsection then qualifies that the "choice of health care professional" for a child – made by the participant, beneficiary or enrollee -- "must permit the designation of a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider" if the physician is in network and available to take the child as a patient. This language appears to eliminate the option of designating a pediatric nurse practitioner or family nurse practitioner for pediatric primary care, an oversight that could affect tens of thousands of pediatric visits per year.

Pediatric nurse practitioners and family nurse practitioners are a significant source of primary care for children. In addition to meeting stringent standards of education, training and licensure in order to qualify as a nurse practitioner, pediatric nurse practitioners must also have specialized education, training and knowledge in the care of children. The ANA Scope and Standards and Practice has defined pediatric nursing, for all registered nurses, as

> the protection, promotion, and optimization of health and abilities for children of newborn age through young adulthood. Utilizing a family-centered care approach, pediatric nursing includes the prevention of illness and injury, the alleviation of suffering through the diagnosis and treatment of the child's response, and advocacy in the care of children and families. (p.xi)[1]

The 2004 National Sample Survey of Registered Nurses (NSSRN), conducted every four years by the Bureau of Health Professions, US Health Resources and Services Administration, notes there were 19,419 advanced practice registered nurses (APRNs) who specialized in pediatric care. Of these, membership survey data compiled by National Association of Pediatric Nurse Practitioners suggests that roughly 58% (of their membership) practice pediatric primary care, while the rest reported practice in subspecialties or acute care. NSSRN data reveals another 60,146 APRNs whose specialty was family care, which often includes pediatric primary care.

To preclude these health care professionals from being designated by patients as their preferred in-network pediatric primary care provider – as does the current IFR -- would be to deny the very rights to patients that the regulatory provision professes to protect, that of freedom of choice of health professional.

ANA recognizes that the interim final regulation follows the letter of the language of the ACA, amending Section 2719A(c) of the Public Health Service Act, which refers specifically to physicians who specialize in pediatrics as among those who could be designated as a child's primary care provider. While this language creates a required element of the implementing regulations, it does not preclude the pertinent Departments from recognizing an additional pediatric primary care provider: nurse practitioners who also specialize in pediatrics. Indeed, current practice patterns and the needs of the pediatric population strongly recommend such an inclusion in the implementing regulations.

The narrow definition of a health care professional reflected in the pediatric provision is particularly anomalous, given that the subsequent provision (3), "Patient access to obstetrical and gynecological care," speaks of the "participating health care professional who specializes in obstetrics and gynecology," which would include certified nurse

[1] American Nurses Association, National Association of Pediatric Nurse Practitioners and Society of Pediatric Nurses. Pediatric Nursing: Scope and Standards of Practice (2008). Silver Spring, MD: American Nurses Association.

midwives (another category of advanced practice registered nurse), as well as obstetrician-gynecologists (allopathic and osteopathic physicians).

The proposed regulatory provision also seems to undermine other provisions of the ACA that provide incentives for pediatric workforce strengthening and expansion. Section 5203, for example, establishes a pediatric specialty repayment program for individuals who are willing to practice in a pediatric medical or surgical subspecialty or in child mental and behavioral health care (including substance abuse prevention and treatment services) full time for at least two years in an underserved area. A "qualified health professional" under the provision, includes psychiatric nurses, social workers, professional and school counselors, and mental health service professionals with training or clinical experience in child and adolescent mental health. It gives priority to applicants who are or will be working in a school setting, have a familiarity with evidence-based care, and can demonstrate financial need. The loan program is not limited to pediatric physicians.

The IFR estimates that there are 11.8 million individuals under the age of 19 with employer-sponsored insurance who are in an HMO plan (Federal Register, 75(123), p. 37211). It is reasonable to deduce that many other children are covered by individual market plans. Among these are infants and toddlers requiring well baby/children care, and a growing number of adolescents and young adults with special healthcare needs, chronic conditions, and disabilities who need a pediatric primary health care professional to coordinate and manage their care.

In their comprehensive 2005 study, "The Pediatrician Workforce: Current Status and Future Prospects," David C. Goodman, MD, MS, and the American Academy of Pediatrics Committee on Pediatric Workforce, note that:

> the growth in training programs for both physician assistants and nurse practitioners greatly exceeds primary care physician residency growth, and therefore the availability of nonphysician clinicians will also grow faster than that of pediatricians. The growth in numbers has also been accompanied by an expansion of practice independence and prescription authority. Both greater numbers and practice autonomy are likely to lead to much larger roles of nonphysician clinicians in pediatric medical care. (p.7, at http://pediatrics.aappublications.org/cgi/reprint/116/1/e156)

The number and distribution of pediatric primary care providers must meet the growing needs of the country's youth, including those children who will be among the 32 million newly insured individuals under the ACA.

In sum, it makes no sense, in either policy or practice, to exclude pediatric nurse practitioners from the pool of those health care professionals who can be designated as pediatric primary care providers. The IFR should be corrected to include primary care advanced practice registered nurses, and in particular pediatric nurse practitioners, so

as to fully guarantee patient rights and protections and their "choice of health care professional," as is the purported intention of both the law and the IFR.

ANA is also seeking modification of model language offered in the IFR as guidance to plans and issuers required under law to provide notice to participants, beneficiaries, and enrollees, to inform them of their rights to certain protections under the ACA. This notice requirement and model language appear in subsection (a)(4), "Notice of right to designate a primary care provider," in each of the three iterations of the patient protections described in the IFR. The modification recommended is meant to incorporate the inclusion of pediatric advanced practice registered nurses, noted above, in the notice of rights and protections.

The language modification ANA is seeking is as follows, in each of the three identical provisions:

> "(4) *Notice of right to designate a primary care provider* – (i) *In general.* If a group health plan or health insurance issuer requires the designation by a participant, beneficiary or enrollee of a primary care provider, the plan or issuer must provide a notice informing each participant (in the individual market, primary subscriber) of the terms of the plan or health insurance coverage regarding designation of a primary care provider and of the rights –
> (A) Under paragraph (a)(1)(i) of this section, that any participating primary care provider who is available to accept the participant, beneficiary, or enrollee can be designated;
> (B) Under paragraph (a)(2)(i) of this section, with respect to a child, that any participating ~~physician~~ health care professional who specializes in pediatrics can be designated as the primary care provider; and
> (C) Under paragraph (a)(3)(i) of this section, that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology."
>
> (ii) [same]
>
> (iii) *Model language.* The following model language can be used to satisfy the notice requirement described in paragraph (a)(4)(i) of this section:
> (A) [same]
> (B) For plans and issuers that require or allow for the designation of a primary care provider for a child, add:
> For children, you may designate a pediatrician or nurse practitioner who specializes in pediatrics as the primary care provider.

(C) [same]"

Section 2711 of the PHS Act, Lifetime and Annual Limits (26 CFR 54.9815-2711T, 29 CFR 2590.715-2711, 45 CFR 147.126).

ANA would also like to express concern regarding the reinstatement opportunities for people who obtain their coverage in the individual market (Overview on p.37191 of the Notice). If an individual reaches their lifetime limit but are still eligible under a group plan, he or she would be reinstated. Under an individual plan, though, an individual cannot be reinstated if he or she has dropped the coverage or the plan wasn't renewed. This distinction appears counterintuitive; why would someone who was denied further benefits – due to a monetary cap – renew or continue paying for their coverage? Failing to renew the coverage because it was no longer useful, the individual would not be eligible for reinstatement even though the regulation's other requirements might make the plan useful again to that individual. This seems like a no win situation for these people. **ANA recommends that this provision be reconsidered, such that reinstatement would be equally available to both group and individual market beneficiaries, participants, or enrollees.**

Section2712 of the PHS Act, Prohibition on Rescissions (26 CFR 54.9815-2712T, 29 CFR 2590.715-2712, 45 CFR 147.128).

Under the "Prohibition of Rescissions" provisions of the ACA, prior notice is required when coverage is rescinded (for permissible reasons), and that coverage – whether in the group of individual market -- cannot be cancelled without this prior notice. This, in itself, is a laudable provision; however its implementation requires reconsideration. The IFR says that a 30-calendar-day notice to an individual is adequate opportunity to explore rights to protect or to find new coverage.

This timeline is inadequate and unreasonable for many beneficiaries, participants, or enrollees. Insurance plans are complex, even in the new construct under the ACA, in which plans must provide clear and comparable summaries to applicants and beneficiaries, participants, or enrollees. Many people do not have access to the Internet, which might otherwise help to facilitate such comparisons in such a short time span. Furthermore, it seems unlikely that a plan or issuer would make the decision to discontinue coverage or overall business in fewer than 30 days; their presumed internal timeline suggests that more time would be available to their beneficiaries, participants, or enrollees, to make decisions, as well.

ANA recommends that the rights to protect existing coverage – by contesting the rescission, or to find new, alternative coverage should be extended to 90 days. Less time than this would undermine the very protection that the notice provision is intended to provide, because it would set unreasonable deadlines for people to act on complex financial and personal matters.

Conclusion.

In summary, the main pieces of the IFR implementation provisions make sense and emphasize that the federal provisions are a floor and that stricter state provisions (or state provisions where the federal government is silent) apply. ANA supports these remaining provisions of the IFR, and urges the pertinent Departments to reconsider those three concerns iterated above.

We appreciate the opportunity to comment on this important rule. If we can be of further assistance, or if you have any questions or comments, please feel free to contact Cynthia Haney, JD, Sr. Policy Fellow, at 301-628-5131 or cynthia.haney@ana.org.

Sincerely,

Mary Jean Schumann, MSN, MBA, RN, CPNP
Chief Programs Officer
American Nurses Association