

September 17, 2010

Secretary Kathleen Sebelius
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Comments on OCIIO-9992-IFC, 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

Dear Secretary Sebelius:

Preventive health care is an important issue in the Asian American and Pacific Islander (AAPI) community. Emerging data on AAPI subgroups clearly demonstrate that there are important disparities in health status, as well as ongoing cultural and linguistic barriers, that inhibit AAPIs from accessing health services. As a result, the undersigned national AAPI community advocacy organizations offer our 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 (PPACA).

We offer our strong support for the requirements that insurers cover preventive services without cost-sharing requirements. We also offer recommendations for strengthening the Rules, including a recommendation to eliminate unnecessary and unreasonable delays in the extension of these critical protections to women's preventive services, to ensure the inclusion of Hepatitis B virus testing, and to establish disaggregate data analysis as an important tool for ongoing preventive care management.

The importance of preventive services for the AAPI population

The historic PPACA law includes significant improvements for vulnerable AAPI populations and we support efforts to extend preventive care for these communities. Prevention programs are important for AAPIs since they are significantly less likely than non-Hispanic whites to receive recommended levels of screening, counseling, or care and face additional barriers that reduce accessibility of important health programs and services. As a result, AAPIs are at increased risk for diseases that are preventable. Studies have found that the cervical cancer rate for Vietnamese American women is five times higher than that of white women, representing the highest rate for any racial or ethnic group.¹ In another example, diabetes is the fourth leading cause of death for API females and sixth leading cause of death for API males.² While many factors contribute to the high rates of preventable diseases among AAPI individuals, including lack of culturally and linguistically appropriate services, the lack of health insurance and knowledge about preventive care within AAPI communities push available services out of reach. Thus, requirements for insurers to include preventive services without cost-sharing requirements, is a critical benefit for AAPI communities and efforts to decrease health disparities.

¹ National Asian Women's Health Organization (NAWHO), *Learning from Communities: A Guide to Addressing the Reproductive Health Needs of Vietnamese American Women* (1998).

² National Center for Health Statistics, 1999

Recommendation I: Eliminate unnecessary and unreasonable delays in extending critical protections to women

Preventive health services are critically important for the health of the AAPI community and contraception is an essential tool in preventing negative health outcomes for women and children. While research data on the reproductive health of API women is scarce, the few studies that do include such information indicate that API women have disproportionately high rates of unplanned pregnancies and low utilization of contraceptives. This is largely a result of linguistic, cultural, and financial barriers that reduce AAPI women's access to contraceptive options. However, comprehensive contraceptive care is recognized throughout the mainstream medical community as essential for reducing both unintended pregnancies and a host of preventable health problems affecting both women and children. According to the Association of Maternal and Child Health Programs, children born of unplanned pregnancies are more likely to be born prematurely, have lower birth weights and higher rates of infant illness and death. Additionally, women who experience unplanned pregnancies are less likely to seek prenatal care and more likely to suffer complications and morbidity during pregnancy and childbirth.

Within PPACA, Section 2713(a)(4) expands the prevention requirements to include preventive care and screenings for women as recommended by guidelines supported by the Health Resources and Services Administration (HRSA). The Rules state that the Department of Health and Human Services (HHS) is developing the HRSA guidelines for women's preventive health services to be covered and exempted from cost-sharing under this provision of the law. HHS has elaborated on this plan, explaining that HRSA is contracting the Institute of Medicine (IOM) to make recommendations about which women's preventive health services should be included in the HRSA guidelines. With respect to timing, the Rules state that HHS expects to issue the HRSA guidelines no later than August 1, 2011 and that insurers do not have to change coverage or cost-sharing requirements until a year after the guideline goes into effect. If the Department proceeds as outlined in the Rules, insurers will not be required to comply with the HRSA guidelines for women's preventive health services until two years after the rest of the Sec. 2713 protections go into effect.

The clear scientific consensus and federal health policy history in support of providing contraception services as an essential component of standard preventive health care is matched by strong public support for ensuring coverage of contraception.³ Yet, the proposed plan and timeline impose unnecessary and unreasonable delays on the extension of these critical protections to women, and we are urging HHS to revise the Rules to eliminate those delays. We propose the following revisions to the Rules to tighten the timeline of the process without undermining medical legitimacy of the HRSA guidelines.

- A. Establish a two-step process for the IOM. In the first step, IOM will identify services recognized by the mainstream medical and public health communities as part of the standard of care, with clear evidence supporting their inclusion on the list of services protected from cost-sharing. A list of these services will be forwarded immediately to HRSA, which will create an interim guideline mandating coverage of, and prohibiting cost-sharing for, those services. IOM will then complete its review and discussion of the remaining services, and formulate its recommendations on the timeline proposed in the Interim Final Rules. This process will ensure that IOM is able to bring the full strength and integrity of its

³ <http://www.nwlc.org/resource/opinion-survey-reproductive-health-coverage-health-reform>

review to the recommendations without imposing an unnecessary and unreasonable delay in the timeline for implementing the women’s preventive health provision of the law.

- B. Put insurers on a faster timeline for compliance. The Rules unnecessarily apply a one-year interval between when the women’s preventive health guidelines are completed and when they will become effective for new plans. Again in light of the compelling public health value of bringing the benefits of the provision to women, HHS should set a shorter interval of one month for compliance with the guidelines. Should the IOM process be amended as recommended above, the shorter interval would apply for both HRSA’s interim and final guidelines.

Recommendation II: Include routine testing for Hepatitis B Virus Infection

Hepatitis B virus (HBV) is the most common blood borne infection in the world and disproportionately affects AAPIs both globally and within the US. Although Asian Americans and Pacific Islanders account for only 5 percent of the American population, they comprise more than 50 percent of Americans living with chronic hepatitis B.⁴ An estimated one in ten foreign-born Asian Americans or Pacific Islanders are living with HBV.⁵ Up to two-thirds of Asian immigrants to the United States have been exposed to HBV.⁶ Unfortunately, the lack of routine HBV screening in Asian American and Pacific Islander communities in the United States leads to elevated rates of liver cancer – members of these communities are 2.7 times more likely to develop liver cancer and 2.4 times more likely to die from the malignancy than are Caucasians.⁷

As HHS is aware, the CDC updated its recommendations for HBV testing in 2008.⁸ The CDC now recommends that the following groups be offered testing for HBV infection as a part of routine care: persons born in geographic regions with HBV prevalence above two percent;⁹ persons with behavioral exposures to HBV;¹⁰ persons receiving cytotoxic or immunosuppressive therapy;¹¹ persons with liver disease of unknown etiology; hemodialysis patients; all pregnant women; infants born to HBV positive mothers; persons with household, needle-sharing, or sexual contacts of HBV-positive persons; persons

⁴ IOM REPORT, *supra* note **Error! Bookmark not defined.**. Some estimates are that 1 million Asian Americans are now living with chronic hepatitis B. See Department of Health & Human Services, Office of Minority Health. *National Hepatitis B Initiative for Asian Americans and Pacific Islanders: Background* (2008). Available at <http://www.omhrc.gov/templates/content.aspx?ID=7240&lvl=2&lvlid=190>.

⁵ Office of Minority Health, *Chronic Hepatitis B in Asian Americans, Native Hawaiians and Other Pacific Islanders: Background* (2008).

⁶ Nguyen TT et al. *Hepatitis B Awareness, Knowledge, and Screening Among Asian Americans*. JOURNAL OF CANCER EDUCATION (2007). 22:266-272.

⁷ Lin S et al., *supra* note **Error! Bookmark not defined.**.

⁸ Centers for Disease Control and Prevention. *Recommendations for Identification and Public Health Management of Persons with Chronic Hepatitis B Virus Infection*. 57 MORBIDITY & MORTALITY WKLY REP. 1-20 (2008) (*hereinafter* “CDC Recommendations”).

⁹ This recommendation includes practically all African, Asian, Middle Eastern, and Pacific Island nations, as well as much of Eastern Europe and South America.

¹⁰ This recommendation includes injection drug users and men who have sex with men.

¹¹ Including chemotherapy, immunosuppression related to organ transplantation, and immunosuppression for rheumatology or gastroenterologic disorders.

who are the sources of blood or body fluids resulting in an exposure to others that might require post-exposure prophylaxis; and HIV-positive persons.¹²

Hepatitis B vaccination is included in the preventive care and screening guidelines. The CDC recommendations are supported by not only the American Association for the Study of Liver Disease (AASLD), but by numerous patient advocacy organizations as well. Implementation of HBV testing and vaccination recommendations would lead to the elimination of HBV transmission in the US.

A striking example of the failure of past HBV testing coverage is the continued perinatal transmission of HBV in the US. Each year an estimated 1,000 infants are chronically infected with HBV.¹³ Expanding HBV testing access to all individuals in at-risk groups will lead to reduced rates of perinatal and transmission and increase the proportion of individuals aware of their chronic HBV status. We thus believe that expanded insurance coverage of preventive services (such as those subject to PPACA, Section 2713(a)(4)), can lead to expanded utilization as well as to substantial benefits to both patients and society.¹⁴

We urge HHS to ensure inclusion of routine testing for the HBV infection as recommended by the Centers for Disease Control and Prevention (“CDC”) guidelines on preventive care and screening as described in the PPACA, Section 2713(a)(4). Increased access to HBV testing would decrease the estimated 65% of chronically infected individuals who are unaware of their infection while improving health outcomes and decreasing health care costs.

Recommendation III: Increase Disaggregate Data Collection for Prevention Programs Involving Mental Health and Alcohol, Tobacco and Other Drugs:

1 . On February 10, 2010, Dr. Howard Koh, Assistant Secretary for Health, DHHS, stated that prevention is one of his top priorities and that substance abuse prevention among all populations is an important behavioral risk factor that must be addressed. HRSA has also identified prevention as a priority, including mental health and substance abuse as behavioral risk factors.

We urge HHS to include better CDC and SAMHSA disaggregated data for AAPI populations in order to monitor, prevent, treat and support the recovery and wellness of these groups in terms of substance abuse and mental health issues. The Youth Risk Behavior Survey, CDC (2009) for the Pacific Island Jurisdictions indicates that these teenage populations have higher prevalence rates for alcohol use, youth violence, depression and suicide than the total U.S. population. However, this survey must be conducted at least every two years to monitor the trends in prevalence rates. Screening for these issues should be done in primary healthcare settings as part of prevention.

2 . Excessive alcohol consumption is the third leading cause of preventable death and illness in the U.S. (CDC, MMWR, 2004). Alcohol use and abuse among AANHPI populations is the most prevalent behavioral health issue in terms of substance abuse, based upon the YRBS data in the Pacific Island

¹² *CDC Recommendations, supra* note 8, table 4. The CDC also maintains a table of its recommendations at <http://cdc.gov/hepatitis/HBV/PDFs/ChronicHepBTestingFlwUp-BW.pdf>.

¹³ IOM (Institute of Medicine). 2010. *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*. Washington, DC: The National Academies Press

¹⁴ See 75 Fed. Reg. 41,733 (citing Jonathan Gruber, *the Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond*, Kaiser Family Foundation (Oct. 2006)).

Jurisdictions (2009) and California (Healthy Kids Survey, (2006). More research, prevention, treatment and recovery programs are needed to address this basic, health issue among AANHPI populations. Better NIAAA and SAMHSA disaggregated data is needed for alcohol use and abuse. Screening for alcohol consumption should be done in primary healthcare settings as part of prevention.

3 . Tobacco smoking and associated pulmonary disease is the third leading cause of preventable death and illness in the U.S. (Nuorti, et al 2000). California data showed that 21% of Pacific Islanders and 13% of Korean teenagers smoked daily (Healthy Kids Survey, 2006). Better CDC and SAMHSA disaggregated tobacco smoking data is needed for the states of California, New York, Hawaii, Texas and the Metropolitan Washington, DC area and the six Pacific Island Jurisdictions. Screening for tobacco use should be done in primary healthcare settings as part of prevention.

4. The U.S. Surgeon General's Report on Mental Health (2001) stated that the prevalence rate for mental disorders among adults and children in the U.S. was about 21%. Serious Psychological Disorders among Native Hawaiians and Pacific Islanders was about 12% (NSDUH, 2008). Suicide is the third leading cause of death among 10- 19 year olds in the U.S. (Frankenfield, et al, 2000). The YRBS data for Pacific Island Jurisdictions (2009) showed that suicide thoughts and depression was generally higher than the total U.S. average. Depression and suicide risks among some AANHPI groups are higher than other populations (NIMH, 2007). Better NIMH, CDC and SAMHSA disaggregated data for mental health issues are needed for the AANHPI populations on the Continental U.S., Hawaii and the six Pacific Island Jurisdictions. Screening for mental health issues should be done in primary healthcare settings as part of prevention for these and other populations.

Recommendation IV: Establish a process for periodic updates to the HRSA guidelines based on science and evidence

The law and the Rules fail to articulate a process that HHS can use to update the preventive health services guidelines. As indicated above, the lack of disaggregated scientific data on AAPI subgroup health status continues to result in adverse health outcomes for our communities. As research progresses, it will be important that the guidelines be updated to reflect advancing knowledge about the services that evidence supports for preventive health care, especially in disease areas that AAPI communities are known to have disproportionate risks. The Rules should establish a process that ensures that the list of covered services is periodically updated to reflect the most current evidence available, as well as advances in technology and changes in clinical practices. This process must ensure that determinations and updates to the guidelines are based on science and evidence.

We look forward to working with you on the implementation of these provisions of PPACA to ensure that women and our families receive the full benefits of coverage for preventive health services with protection against cost-sharing burdens that serve as a barrier to care and to better health.

Sincerely,

National Asian Pacific American Women's Forum
Association of Asian Pacific Community Health Organizations
National Asian American Pacific Islander Mental Health Association
Organization of Chinese Americans
South Asian Americans Leading Together
Asian & Pacific Islander American Health Forum