December 26, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9972-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Comments on Proposed Rule on Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review [RIN 0938-AR40]

Dear Sir or Madam:

Young Invincibles is a non-profit, non-partisan organization that works to amplify the voices of young Americans and expand economic opportunity for our generation. As one of the leading organizations focusing on young adults and health care, we thank you for this opportunity to comment on the *Health Insurance Market Rules*. The important changes to the health insurance market will provide considerable protections to young people across the country. We urge you to take a few additional steps to ensure that this generation can take full advantage of the benefits offered by the Affordable Care Act. Specifically, we ask that HHS:

1. Adopt a broad definition of who will be included under family coverage;
2. Consider defining adult at a later age when starting age rating, if young adult enrollment proves to be at risk;
3. Include student health insurance in the broader risk pool, ensuring that the more uninsured, low-income young people and students who are not enrolled in colleges that provide insurance do not get unfairly harmed;
4. Take broader definitions of the primary care visits to be provided by catastrophic plans, and ensure that those visits 1) are available with no co-pay and 2) do not count against the preventive care coverage also provided.

Taking these steps will ensure that the broadest group of young people gains quality, affordable coverage as a result of the market reforms discussed in this proposed regulation.

1. Persons Included Under Family Coverage

Allowing issuers to define family leaves open the real possibility that young

people may be excluded from affordable coverage due to their relation with their family. HHS should further define family to avoid that outcome.

a. We urge HHS to define broad minimum categories of family members that insurers must allow to be on the same family policy.

We urge HHS to specify broad minimum categories of family members that health insurance issuers must include in family policies – rather than deferring to the states and health insurance issuers to make this determination – to ensure that as many young people as possible can be covered under their parents' or guardians' policy should they choose. Doing so will further the clear intention of the ACA to dramatically increase coverage by ensuring that a large number of previously uninsured youth obtain insurance.

By allowing issuers or states to have control over defining who is a family member, HHS would leave open the very real possibility that plans could deny coverage to large numbers of individuals commonly thought of as family members – in particular, adopted children and stepchildren. In 2004, an estimated 5.5 million children lived with a stepparent, and 1.5 million children lived with an adoptive parent.[1] Giving issuers or states the option of denying coverage to these children would undermine the fundamental purpose of the ACA. An HHS definition of minimum categories of family members to be included in family policies should include, at a minimum, the employee or individual market policyholder; a spouse or partner; biological children; adopted children; children placed for adoption; stepchildren; foster children; and children under guardianship. Adopting broad minimum standards will create uniformity in coverage across states and promote enrollment in insurance coverage.

Further, expressly covering adopted children and stepchildren on family policies is consistent with federal policy. Section 152 of the Tax Code defines "child" to include both stepchildren and adopted children, giving them identical tax benefits as biological children regarding medical expenses.[2] The ACA incorporated this definition of child when extending favorable tax treatment for medical care reimbursement to adult dependents.[3] The Employee Retirement Income Security Act (ERISA) also prohibits discrimination against dependent coverage for adopted children for all group plans under its jurisdiction.[4] The regulations should extend the logic of these rules so more dependents can be included in family coverage.

---

[1] Rose M. Kreider, *Living Arrangements of Children: 2004* (Washington, DC: U.S. Census Bureau, 2008), 2, 9, accessed December 20, 2012, available at http://www.census.gov/prod/2008pubs/p70-114.pdf. Numbers based on children under the age of 18.

[2] 26 U.S.C. § 152(f)(1); 26 U.S.C. § 105(b).

[3] *Notice 2010-38: Tax Treatment Of Health Care Benefits Provided With Respect To Children Under Age 27* (Washington, DC: Internal Revenue Service, 2010), accessed December 21, 2012, available at http://www.irs.gov/irb/2010-20_IRB/ar08.html.

[4] Specifically, ERISA states that "in any case in which a group health plan provides coverage for dependent children of participants or beneficiaries, such plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries under the plan, irrespective of whether the adoption has become final." 29 U.S.C. § 1169(C)(1).

The availability of family coverage for young adults has allowed millions of young people to obtain coverage over the past few years, and a broad floor in defining family members could help millions more going forward.

2. Rating of Age

The proposed regulation describes how the 3:1 age rating, prescribed by the Affordable Care act, will impact rates at each age. We support the proposal to implement age rating based on age at time of enrollment, and comment more broadly on the impact of the age rating requirement. Recent census data shows that most of the uninsured (and insured) population will qualify for subsidies, and many may enroll in cheaper catastrophic plans, two protections that will cushion this population from much of the premium impact of this provision. However, while young people have both a societal and individual interest in ensuring that older adults can afford to purchase coverage, no one benefits if young people who are not protected by this cushion do not buy on exchanges. If evidence does show that the low to moderate income young consumers will choose not to enroll due to the rating change, there are steps that HHS could take within the confines of the ACA's requirements. First, HHS could start the adult age rating curve at age 26 – the age at which dependent coverage ends – instead of age 21, to keep premiums low for young adults in their early 20s who may just be entering the individual market. Second, HHS could further adjust the age band curve to minimize the impact of younger consumers.

a. *We support basing the rating by age on a consumer's age at the time of policy issuance or renewal.*

First, we support basing age rating premium adjustments on a consumer's age at the time of policy issuance or renewal. This will ensure 1) that consumers pay a consistent price for coverage throughout the year and 2) accurate and efficient administration of advance premium tax credits, which will be adjusted for age-related variation in premiums. If another measurement point (such as birthdays) is used, it would impede both of these goals. If premiums increased on birthdays, then all consumers in the individual market would see a premium increase during the year, unless prohibited in their state. Advance payments of premium tax credits would also need to increase, and the exchange would be responsible for ensuring this occurs for all people at the time of their birthdays. This would increase administrative costs, likely confuse consumers, and — if adjustments are not made on a timely basis — result in consumers incurring higher premiums without concurrent adjustment in subsidies. The final rule should maintain the proposal to restrict age-related premium variation only at policy issuance and renewal.

b. *The availability of tax credits, dependent coverage, and catastrophic plans mitigates much of the impact of the 3:1 age rating limit for the majority of young consumers, but HHS could take further steps if data shows that those protections are not enough.*

The change in age rating may increase premiums for young people in the individual market, however, the reality is more nuanced: most young people will also receive protection from those increases through subsidies and access to reduced-cost coverage such as dependent coverage and catastrophic plans. In other words, age rating may not impact the actual price that most young people pay. But for those who do not receive those protections, we offer additional actions that HHS can take to keep premiums down.

Young people have both a societal and individual interest in ensuring that older adults can also afford to purchase coverage, but young people may also simply choose not to purchase coverage if premiums are too expensive.[5] Certainly, research has shown that price does have a bigger effect on young people's decisionmaking regarding insurance.[6] Keeping in mind both the protections available and the importance of young adult enrollment, we offer a more detailed analysis of the impact of age rating.

For example, out of a total of approximately 21.4 million young adults ages 21 to 25 (inclusive), about 1.3 million were insured through a direct-purchase plan in 2011, and about 6.2 million were uninsured – most of whom will receive subsidies in 2014.[7] The charts below shows insurance coverage in this age cohort by income level, measured by federal poverty level (FPL).

Insurance Coverage of Young Adults Age 21-25, by Income – 2011[8]

		Uninsured		*Insured*	
	Total	No.	% of total	No.	% of total
Overall	**21,429,000**	**6,235,000**	**29.10%**	**15,194,000**	**70.90%**
0-300% FPL	13,256,000	4,961,000	37.42%	8,295,000	62.58%
300-400% FPL	2,733,000	591,000	21.62%	2,142,000	78.38%
400-600% FPL	2,939,000	443,000	15.07%	2,496,000	84.93%
600%+ FPL	2,501,000	240,000	9.60%	2,261,000	90.40%

[5] Issuers have stated concerns that premium rates will increase for all young people when the market moves to a 3:1 age rating ratio. For example, America's Health Insurance Plans (AHIP), notes that 42 states currently have age rating ratios of 5:1 or more and argues that limiting age rating to 3:1 will cause significant increases America's Health Insurance Plans (AHIP), "Age Rating," accessed December 21, 2012, available at http://www.ahip.org/Issues/Age-Rating.aspx. These estimations often fail to take into account the upfront protections like access to subsidies and catastrophic plans.

[6] *See e.g.*, Strombum et al., *Switching costs, price sensitivity, and health plan choice*, Journal of Health Economics (2002). This study found that younger, healthier employees were two to four times more sensitive to price than older, less healthy employees when it came to switching plans. However, a review of insurance levels in states that adopted tighter age bands did not reveal discernable trends. YI Analysis of U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, Years 1993 - present.

[7] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2012," accessed December 21, 2012, available at http://www.census.gov/cps/data/cpstablecreator.html. However, it is unclear whether that category includes student health insurance.

[8] *Ibid.*

		Insured through direct-purchase		*Insured through another type of plan*	
	Total	No.	% of insured	No.	% of insured
Overall	**21,429,000**	**1,258,000**	**8.28%**	**13,936,000**	**91.72%**
0-300% FPL	13,256,000	681,000	8.21%	7,614,000	91.79%
300-400% FPL	2,733,000	184,000	8.59%	1,958,000	91.41%
400-600% FPL	2,939,000	202,000	8.09%	2,294,000	91.91%
600%+ FPL	2,501,000	191,000	8.45%	2,070,000	91.55%

Of the total 6.2 million uninsured age 21 to 25, approximately 5 million individuals earn below 300% FPL[9] and will receive substantial subsidies to cover the cost of health insurance. Fortunately, this population, which is likely to be the most sensitive to price, will be substantially protected through the subsidies. An additional 600,000 uninsured 21- to 25-year-olds are between 300% and 400% FPL[10] and will receive smaller premium subsidies and be somewhat protected; 450,000 are between 400% and 600% FPL and would be the most likely to feel the impact of age rating requirements.[11] Of those already currently purchasing individual coverage, about 386,000 fall in the income ranges of 300% – 600% FPL. In other words, about 17 percent of the currently uninsured and 2.5 percent of currently insured 21-25 year-olds will see an actual impact of the age rating changes.

In 2014, this age group will also have access to catastrophic plans offering significantly lower premiums (but also less coverage), and today's trends indicate that this will be a popular option.[12] The mitigating effect of subsidies and catastrophic plan availability make the calculation of age rating impact much more complex. Any analysis on enrollment impact should focus specifically on this low to moderate-income cohort of young adults least likely to have access to substantial subsidies and perhaps wary of catastrophic plans.

The premium jump proposed presents another concern. Under the proposed rule, 21-year-olds with individual coverage could potentially experience a premium increase of about $90 per month – or about $1,100 per year – when they move from the child curve, with a proposed band of 0.635, to the start of the adult curve at a ratio of 1.000. To estimate the impact of this jump, we chose a plan on today's market that would be

[9] *Ibid.*
[10] *Ibid.*
[11] *Ibid.*
[12] Catastrophic plans are a popular item in today's marketplace, presumably because they are the lowest cost option. In fact, the average deductible for an 18-24 year-old purchasing insurance on eHealthInsurance was about $3,000. EHealthInsurance, *The Costs and Benefits of Individual and Family Health Insurance Plans*, (2011), accessed December 26, 2012, http://news.ehealthinsurance.com/pr/ehi/document/2011_Cost__and__Benefits_Report_FINAL.pdf.

somewhat comparable to a bronze plan.[13] The estimated premium for this plan for a 21-year-old is $249 per month. Using that as an example baseline for "1.000", a 20 year-old could see a jump from a .635 rate at a $158 monthly premium up to a 1.000 rate at a $249 premium – a $1,092 premium increase for the year.

If evidence does show that this population of low to moderate-income young adults will choose not to enroll, HHS may consider whether the below options would ease the overall premium increases and the premium jump for this population:

- HHS could push back the adult age rating curve to start at age 26 instead of age 21. Twenty-six is also a logical age at which to start the adult age rating curve because it is the age at which an individual ages out of dependent coverage and foster youth age out of Medicaid in 2014. The ACA does not define who is an adult for purposes of the adult age curve,[14] so HHS has flexibility in setting the start of the curve. The chart below demonstrates this method, and assumes a linear increase in the premium ratio from age 20 to age 26. A curve based on actual premium variation might look different.
- HHS could also decide to extend the child curve of .635 to age 25, keeping premiums low through the early 20s but then seeing a substantial jump at age 26.
- HHS could further flatten the adult age rating curve so that premiums increase more gradually for younger adults and more quickly for middle age adults; young adults could stay at a "1.000" band longer.

"Graduated" Standard Age Curve

	Age	Premium Ratio	Est. Monthly Premium	Est. Annual Premium	Est. Monthly Premium Increase	Est. Annual Premium Increase
Child Curve	0-20	0.635	$172	$2,064	NA	NA
Graduated transition between child and adult curve	21	0.696	$189	$2,268	$17	$204
	22	0.757	$205	$2,460	$16	$192
	23	0.818	$222	$2,664	$17	$204
	24	0.879	$238	$2,856	$16	$192
	25	0.940	$255	$3,060	$17	$204
Adult Curve	**26**	**1.000**	**$271**	**$3,252**	**$16**	**$192**
	...	...	...	...	...	...

[13] We chose a plan comparing it to estimates published by the Kaiser Family Foundation, a plan with a $2,750 deductible and 30% coinsurance level would meet the ACA standards for the bronze plan (a 60% actuarial value and $6,350 out-of-pocket maximum). Aetna's CA Open Access Managed Choice 2750 plan is an example of a comparable plan currently on the market.

[14] *See* 42 U.S.C. 300gg(a)(l)(A)(iii).

In conclusion, any mitigating steps to encourage enrollment among young consumers should be targeted at the more narrow range of young people not receiving subsidies or enrolling on catastrophic plans: in other words, those who have some income but may still struggle. We offer HHS several action steps if evidence shows that this population is unlikely to purchase coverage; any additional actions taken should focus on the low-to-moderate income cohort of young adults identified in our analysis.

3. Student Health Insurance Coverage and the Single Risk Pool

The Affordable Care Act will bring student health insurance up to standards required of the rest of the industry. These proposed regulations also require that issuers pool student health insurance plans with other individual market insurance. Such a requirement would ultimately protect more young people looking to enroll in plans on the individual market.

a. *We support the proposal to include student health insurance coverage in an issuer's individual market single risk pool, as long as doing so does not stop the student health insurance market from existing.*

We support proposed section 156.80, under which each issuer will have a single risk pool for its business in the individual market that includes student health insurance plans (SHIPs). Including SHIP coverage in the individual market risk pool will spread risk more evenly among consumers, keeping premiums more affordable. In particular, we believe that the inclusion of SHIPs in the individual risk pool will help keep premiums affordable for more low and moderate income young adults, as most do not have access to SHIP coverage. However, a single risk pool for individual and SHIP coverage should not be maintained if it prevents the market from existing.

Uninsured students and the non-student youth population have lower incomes – and thus a greater need for lower premiums – than insured youth who have access to student plans. A 2008 report by the Government Accountability Office (GAO) found that part-time students, older students, students from racial and ethnic minority groups, and students from families with lower incomes, were more likely than other groups of college students to be uninsured.[15] Specifically, in 2006, the average family income for insured college students age 18-23 was $95,000 per year, while the average family income for uninsured college students in the same age range was $52,000 per year.[16] At the same time, schools that offer student health insurance tend to attract and thus cover wealthier students. Between approximately 70 and 80 percent of four-year schools offered student insurance, while only 29 percent of two-year schools offered coverage.[17] This overall

[15] Government Accountability Office (GAO), *Health Insurance: Most College Students Are Covered through Employer-Sponsored Plans, and Some Colleges and States Are Taking Steps to Increase Coverage* (Washington, DC: 2008), 5, accessed December 12, 2012, http://www.gao.gov/new.items/d08389.pdf. In a 2011 survey by Young Invincibles (YI) found that part-time students – who tend to be lower income - are more likely to be uninsured and less likely to be enrolled in SHIPs than full-time students. YI analysis of *State of Young America* poll (cross-tabs available upon request).
[16] *Ibid.*, 15.
[17] *Ibid.*

disparity is important: two-year institutions enroll higher numbers of students and families from lower and moderate-income families.

Overall, the students who need low-cost coverage the most are going to turn to exchanges, not necessarily student coverage, and low and moderate income young people are less likely to enroll in college and have access to SHIPs. Given the comparative economic status of young adults who have or are likely to be able to buy SHIP coverage versus young adults and other students who are uninsured and may need to purchase individual coverage, broadening the individual risk pool by including SHIPs may lead to better health and financial outcomes for the young adult and student population as a whole.

Despite those statistics, SHIP coverage is the best available for many students, particularly older students and those whose parents do not have family coverage. Moreover, it is possible that low-income students at wealthier schools are the ones enrolling in student plans because they lack access to dependent coverage options, though data limitations do not allow us to make that assessment. Complicating this analysis is the fact that some states may not expand Medicaid, leaving student insurance the only viable option for some. Finally, SHIPs may still be more affordable than some exchange options and provide ease of enrollment – students typically enroll at the beginning of the academic year and the premium may be deducted from a student's financial aid disbursement. Maintaining the SHIP market may increase the likelihood that students stay covered. Additionally, the ACA prohibits measures that will stop the SHIP market from existing.[18] For all of these reasons, if including SHIPs in the individual risk pool would alter SHIPs such that the market no longer exists, issuers should instead be able to maintain separate pools for individual and SHIP coverage.

In sum, we support including SHIP coverage in an issuer's individual market risk pool as a way of keeping insurance costs down for young adults and students who are currently uninsured and/or do not have access to SHIPs, because these individuals are likely to have lower incomes than young adults with access to SHIP coverage. However, we recognize that SHIPs are an important resource for many students, and that the ACA protects this resource; therefore, issuers should be permitted to maintain a separate risk pool for SHIP coverage if evidence shows that including it in the individual pool would not longer allow these plans to exist.

4. Enrollment in Catastrophic Plans (Proposed §156.155)

Catastrophic plans will likely provide a popular source of coverage for young adults. On the one hand, subsidies will make premiums for bronze or silver plans less expensive, and even when a catastrophic plan provides a slightly lower premium, the financial strain of out-of-pocket costs will often make a bronze level or higher plan a better deal. Nonetheless, the cost-sharing structure and target population will make this

[18] ACA § 1560(c).

plan the least expensive option, at least upfront, for those who do not qualify for substantial subsidies, and so we anticipate a high level of enrollment.

However, we have concerns about these plans, given the sparse coverage provided before an enrollee pays a $6,250 deductible.[19] Few young people can afford to self-insure up to that amount. We hope that HHS will ensure that issuers maximize pre-cost sharing benefit coverage on catastrophic plans to limit the enormous expense that any care may cost enrollees, and, in building exchanges, ensure that young people are provided with adequate tools to assess the true financial cost of each plan.

For purposes of these comments, we support the HHS proposal to allow catastrophic plan enrollees who reach age 30 during the plan year to stay enrolled for the remainder of that plan year; support the codification of the ACA requirement that prohibits cost sharing for preventive services; ask that HHS codify the ACA's prohibition on cost-sharing for the three required primary care visits; and urge HHS to define primary care visits to provide enrollees with meaningful coverage.

a. *We support proposed section 156.155(a)(5)(i), which bases eligibility for catastrophic plan enrollment on the enrollee's age at the start of the plan year.*

First, we support the HHS proposal in section 156.155(a)(5)(i) on enrollment in catastrophic plans, which (1) allows individuals under age 30 at the beginning of the plan year to enroll in a catastrophic plan and (2) allows catastrophic plan enrollees who reach age 30 during the plan year to stay enrolled until the end of the plan year. Determining eligibility for enrollment at the start of the plan year – rather than on the enrollee's birthday – will simplify the enrollment process for consumers and help ensure that enrollees have coverage for the entirety of the plan year. Determining eligibility based on the individuals age at the start of the plan year would also be consistent with the HHS proposal that age rating adjustments use the enrollee's age as of the date of policy issuance or renewal (proposed section 147.102(a)(1)(iii)).

b. *We commend HHS for codifying the ACA requirement that catastrophic plans may not impose cost sharing for preventive services.*

Second, we commend HHS for clearly stating in paragraph (b) of the proposed rule that catastrophic plans must provide coverage for preventive services at no cost-sharing. This is consistent with both the language and intent of the ACA, and will ensure young adults and other individuals who qualify for catastrophic plans have the same access to basic preventive services as individuals on other types of plans.

---

[19] The annual limit on out-of-pocket expenses for high deductible health plans in calendar year 2013 is $6,250 for self-only coverage or $12,500 for family coverage. Internal Revenue Service (IRS), Revenue Procedure 2012-26,1-2, accessed December 23, 2012, available at http://www.irs.gov/pub/irs-drop/rp-12-26.pdf. We anticipate this number may change in 2014.

c. *We urge HHS to explicitly state that the three primary care visits catastrophic plans must cover must be provided with no cost-sharing.*

Third, we urge HHS in proposed paragraph (a)(4) to explicitly state that issuers cannot impose cost-sharing for the three primary care visits per year that a catastrophic plan must provide pre-deductible. Proposed paragraph (a)(4) currently states that catastrophic plans must "[p]rovide[] coverage for at least three primary care visits per year before reaching the deductible." In the Federal Register notice, HHS notes that it "do[es] not propose here to prohibit an issuer from imposing cost sharing in connection with these primary care visits so long as other applicable law (for example, PHS Act section 2713) permits."[20] We believe that, in fact, the ACA does *not* permit issuers of catastrophic plans to impose cost sharing for the three required primary care visits. Therefore, HHS should clearly state in the final rule that issuers cannot impose cost sharing for these primary care visits.

ACA section 1302(e)(1)(B) describing catastrophic plans mandates that they provide no benefits until an enrollee pays about $6,250 in cost-sharing, *except* that all such plans must cover at least three primary care visits.[21] The language clearly intends that primary care must (not just can) be covered before cost-sharing requirements are met. If HHS maintains the interpretation in the proposed regulation and plans were allowed to impose cost sharing for primary care visits, it could effectively make the stand-alone provision on primary care visits moot: taken to the extreme, insurers could technically impose very high cost-sharing as long as it was less than the $6,250 deductible.

The three primary care visits were offered as a way to give young adults and other qualifying enrollees access to at least basic care; allowing issuers to impose cost-sharing for these visits would defeat the purpose of this provision. Other than preventive services, these three primary care visits are the only benefits that catastrophic plan enrollees receive before paying about $6,250 in cost sharing. In order to encourage catastrophic plan enrollees to visit primary care providers – and stay enrolled in plans that offer few other routine benefits – HHS should make clear that issuers cannot impose cost-sharing for the first three primary care visits.

d. *We urge HHS in the final rule to include a broad definition of "primary care visits" that would ensure the basic health care need of enrollees, including women, are met.*

---

[20] 77 Fed. Reg. 70583 (Nov. 26, 2012), 70601, accessed December 23, 2012, available at https://www.federalregister.gov/articles/2012/11/26/2012-28428/patient-protection-and-affordable-care-act-health-insurance-market-rules-rate-review.

[21] ACA § 1302(e)(1)(B). This section of the ACA, which creates catastrophic plans, specifically references preventive coverage, stating that a plan can provide no benefits until it has incurred requisite cost-sharing "except as provided for in section 2713." Section 2713 of the Public Health Service Act, as added by section 1010(a) of the ACA, states: "[a] group health plan and a health insurance issuer offering group or individual health insurance coverage" shall provide coverage of preventive services with no cost sharing. Thus, catastrophic health plans, like all other new health plans, must cover preventive services with no cost sharing.

Fourth, we urge HHS in proposed paragraph (a)(4) to add a broad definition of "primary care visits." The ACA does not define primary care visits for purposes of catastrophic plans. However, a concrete and expansive definition of primary care visits is necessary to ensure that Congressional intent of providing consumers with access to basic primary and preventive care is realized. As previously noted, catastrophic plans cannot provide any benefits aside from preventive services and these three primary care visits before the enrollee pays about $6,250 in cost sharing.[22] Therefore, consistent with direction and scope of the ACA, HHS should define primary care visit to include the full set of services Americans need to stay healthy.

To begin, HHS should define the scope of the "primary care visit" to meet the health care needs of all Americans. Specifically for women, and consistent with the direct access provision in the ACA, a visit to a practitioner focused on obstetric and gynecological care should be considered a primary care visit. In addition, primary care visit should be defined to include visits to a variety of providers beyond physicians since often patients' health care interactions are with other providers including nurse practitioners and physician assistants.

Significantly, visits to providers for the purpose of receiving preventive services outlined in section 2713 of the PHS Act to be covered at no cost-sharing should *not* be counted as one of the three primary care visits excluded from cost-sharing requirements. In other words, an individual who has not visited a primary care provider in a given plan year, who then sees a primary care provider wholly for the purpose of receiving a preventive service, would still have coverage for three primary care visits at no cost sharing. This is vitally important because most preventive services cannot be administered without visiting a primary care provider.

For example, if an individual with a catastrophic plan receives an immunization from a nurse practitioner in a family physician's office, the visit should not count as one of the three primary care visits exempt from cost-sharing requirements. If preventive services received from a primary care provider are counted against the three primary care visits, people may be discouraged from getting those preventive services for fear that they would then be unable to afford a doctor's visit in case of illness. This would be contrary to the purpose of covering preventive services with no cost-sharing, which is to remove barriers and encourage people to get necessary screenings and immunizations.[23] When people receive recommended preventive care they are better able to avoid serious illness and identify and manage chronic diseases.[24] In addition, preventive services can help

[22] ACA § 1302(e)(1)(B).

[23] For example, one study found that the rate at which women received mammograms increased by 9% when cost sharing was removed. G. Solanki, H. Halpin Schauffler, and L.S. Miller, "The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services," *Health Services Research*, vol. 34, no. 6, February 2000, pp. 1331-1350.

[24] *See e.g.*, S. Woolf, "A Closer Look at the Economic Argument for Disease Prevention," *JAMA* 2009; 301(5):536-538 (finding that colorectal and breast cancer screening, flu vaccines, and counseling on smoking cessation and regular aspirin use – could avert 100,000 deaths each year) and S.J. Curry, T. Byers, and M. Hewitt, eds., *Fulfilling the Potential of Cancer Prevention and Early Detection* (Washington, DC:

reduce the economic costs of illness and disease.[25] Therefore, a visit to a primary care provider to receive a preventive service should not be counted towards an enrollee's three primary care visits exempt from cost-sharing.

Catastrophic plans provide cheaper premiums but may be a potentially risky insurance coverage option for young adults; as such, we encourage HHS to adopt provisions that cover more services for enrollees. To ensure that young adults and other low-income individuals who enroll in catastrophic plans (1) access primary and preventive care and (2) see value in purchasing catastrophic coverage, primary care visits must be defined broadly and provided with no cost-sharing, and preventive care visits should not count against the primary care visits that they receive.

In conclusion, we believe that the market reforms proposed in this rule hold great promise. By making the adjustments suggested above, we believe that HHS can ensure that young adults are able to take advantage of the many benefits offered by the Affordable Care Act. Thank you for your consideration of these comments. Please do not hesitate to email Christina.Postolowski@YoungInvincibles.org with any questions.

Sincerely,

Young Invincibles

National Academies Press, 2003) (finding that effective cancer screening and early and sustained treatment could reduce the cancer death rate by 29%).

[25] *See e.g.*, K. Davis, S.R. Collins, M.M. Doty, A. Ho, and A.L. Holmgren, *Health and Productivity Among U.S. Workers* (New York, NY: The Commonwealth Fund, August 2005).