

August 27, 2010

SUBMITTED ELECTRONICALLY

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
ATTN: OCIIO-9992-IFC
PO Box 8016
Baltimore, MD 21244-1850

Dear Sir/Madam:

We are writing to comment 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 are health care providers and patient advocates with a special interest in digestive diseases.

We are very pleased to see that the PPACA is resulting in a concentrated commitment to providing preventive care consistent with the recommendations of the United States Preventive Services Task Force (USPST), the Advisory Committee on Immunization Practices of the Centers for Disease Control (ACIP/CDC), and the Health Resource and Services Administration (HRSA). We strongly support complete and universal insurance coverage of immunizations, well-care visits, and the whole host of preventive measures recommended by the USPST, ACIP/CDC, and HRSA. We write to express a narrow but important concern.

The USPST, ACIP/CDC, and HRSA recommendations are written for the general public, and for the most part, do not include recommendations regarding the frequency of the preventive measure in question. The interim final rules state 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 coverage limitations.¹ However, the Departments also state that utilization of preventive services will increase when they are covered with zero copayment or coinsurance. We urge the Departments to consider, then, how leaving the "frequency, method, treatment or setting" of the preventive care to insurers will adversely affect their utilization, especially in patients with a higher than average risk profile.

For example, the USPST's recommendation for colorectal cancer states as follows:

[S]creening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.

Colorectal cancer screening was given a rating or grade of A by the USPST.

Patients with inflammatory bowel disease, as well as those who have a history of polyps or colon cancer, have a higher than average risk of developing colorectal cancer. More often than not, we recommend a colonoscopy for most of these patients every one to

¹ 26 C.F.R. § 54.9815-2713T (a)(4); 29 C.F.R. § 2590.715-2713(a)(4); 45 C.F.R. § 147.130(a)(4).

five years, depending on the illness and circumstances. In addition, in this patient population, we believe that colorectal cancer screening colonoscopies should begin before age 50. Thus, while the USPST's recommendations may fit a healthy patient, they do not fit a high risk population. Surely, this is the case with other diseases, as well. For example, a patient with inflammatory bowel disease, dysmotility, or other digestive disease presents a complex dietary picture and, thus, counseling for a healthy diet requires both specialization and additional time. Leaving the decision of whether to pay for a nutritionist versus a primary care provider, along with the number of visits and the complexity of those visits, to an insurance company simply requires us to remain involved in advocating for coverage for our patients. The interim final rules are not clear and specific enough to make coverage automatic.

Thus, we would urge the Departments to consider shifting the decision-making for high-risk patients, i.e., patients who already have at least one chronic illness or previous incidence of colorectal cancer or other disease for which prevention is sought, to the treating physician regarding the "frequency, method, treatment, or setting" for the preventive care. The treating physician should have to provide nothing more than a certification to the insurer that the patient is high risk. This allows physicians to ensure that patients who most need preventive care are getting the type and level of care they need; it ensures that patients will utilize this care because it will be free; and it provides some protection to insurers, who will retain control over "frequency, method, treatment, or setting" for other than high-risk patients.

Again, we very much appreciate the Departments' effort to make preventive care accessible for all patients in need. We agree with the Departments' approach, as well as with the general assessment that both the PPACA and its implementation through the interim final rules, will increase utilization of prevention, resulting in a healthier America.

Thank you.

Sincerely,

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