September 17, 2010

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

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N-5653
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
Attention: RIN 1210-AB44

Internal Revenue Service
CC: PA: LPD: PR, (REG-120391-10)
Room 5025
P.O. Box 7604 Ben Franklin Station
Washington, DC 20044
Attention: REG 120391-10

RE: File Code OCIIO-9992-IFC/RIN 1210-AB44/REG–120391-10, 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, Deputy Commissioner Miller, Assistant Secretary Borzi, Assistant Secretary Mundaca and Director Angoff:

AARP is pleased to comment on the Interim Final Rule (IFR) published on June 19, 2010, in the *Federal Register* implementing the preventive services coverage requirements of the Patient Protection and Affordable Care Act (ACA). The IFR, jointly published by the Departments of the Treasury, Labor and Health and Human Services, addresses section 2713 of the Public Health Service Act as added by the ACA. The provision requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide coverage for certain preventive services without cost-sharing requirements.

AARP strongly supports investments in disease prevention and health promotion because they can save lives, reduce chronic illness and the spread of infectious diseases and help

slow the growth in health care costs. Section 2713 of the law addresses the significant financial barriers faced by many Americans in obtaining preventive services by requiring health plans to cover these services without enrollee cost-sharing requirements.

AARP commends the Departments for their work in developing the IFR in a way that recognizes the critical role of preventive services in improving health outcomes. We believe, however, that certain clarifications and improvements to the implementing regulations are needed to ensure that the ACA's objectives for coverage and increased utilization of preventive services are fully realized.

Frequency of Recommended Preventive Services, Especially for At Risk Populations. Section 2713 of the ACA requires non-grandfathered health plans to cover certain preventive services recommended by the Advisory Committee on Immunization Practices, the United States Preventive Services Task Force (USPSTF), and the Health Resources and Services Administration. These services are termed "recommended" preventive services in the IFR and rules for reimbursement are established for different situations, such as when preventive services are provided in and out of a plan's provider network. The IFR permits plans to use "reasonable medical management techniques" to determine the frequency, method, treatment or setting in cases where this is not specified in the recommendation or guideline.

AARP is concerned that "reasonable medical management techniques" is not defined in the regulation and, if interpreted incorrectly, could impede regular access to preventive services. When a recommendation or guideline does not state frequency, a health plan should be required to identify a credible evidence basis for its coverage decisions. This credible evidence basis should be standardized across plans (e.g., Millman Care Guidelines). The Departments should make it clear that there are appeal rights for beneficiaries who believe they were denied a preventive service without cost-sharing in error. The final regulation should clearly address the issue of enforcement and oversight, including the Departments' authority to monitor health plans' compliance.

Frequency of preventive services is particularly important for high risk populations, including those with chronic health conditions. Health professionals use Health Risk Assessments, annual physical exams or the regular course of health treatments to determine when individuals are at a high risk for developing certain medical conditions. Recommendations and guidelines for preventive services typically do not address frequency for high risk individuals. In these instances, the basis for coverage should be the health professional's recommendation for that individual. In many cases, preventive services are used not simply to screen for new disease but monitor chronic conditions. The regulations should clarify whether an initial screening service is covered without cost-sharing, or whether repeat or more frequent services (when medically indicated) could be classified as screenings for which no cost sharing applies, rather than diagnostic service for which cost-sharing would be imposed.

AARP also suggests that the Secretary of Health and Human Services direct the four designated statutory entities whose recommendations form the basis for the required coverage to provide more specificity, where appropriate, about the clinically appropriate schedules for those at higher risk to ensure that future recommendations take this issue into account.

Preventive Services When Not a Primary Purpose of an Office Visit. The IFR provides that, when a recommended preventive service is not separately billed but included in the bill for the office visit, then the cost sharing rules vary based on the "primary purpose" of the visit. If the primary purpose is the delivery of the recommended preventive service then cost sharing is not imposed on the visit. However, if the primary purpose of the visit is not the delivery of the recommended service then cost sharing may be imposed. The IFR goes on to provide several examples of this distinction.

AARP believes the IFR should provide more clarity on how the "primary purpose" distinction will be made. Health plans, employers, health professionals and individuals need the clearest possible rules and understanding to avoid confusion. The regulations should not encourage a situation where different insurers can make different interpretations of the "primary purpose" or narrow the definition. Since the intent of the statute is to increase the delivery of preventive services, we encourage the broadest possible definition of “primary purpose” that will allow for the most preventive services administered without cost sharing. Where the determination is not made at the time of service, we discourage any requirement of the consumer paying a copayment until such determination can be made between the health practice and the insurer.

Coverage of Preventive Services Obtained Out of Network. Under the IFR, an issuer or group health plan is permitted to charge cost-sharing when an enrollee obtains a recommended preventive service from a provider that is out of the plan’s network. AARP generally supports the use of financial incentives to encourage the use of network providers <u>if</u> the plan network provides for adequate and timely access to covered benefits. However, we are concerned about potential access problems faced by enrollees in network based plans where the network lacks appropriate high quality providers throughout the service area. If enrollees are required to wait months for appointments with a primary care physician, then they face the undesirable choice of delaying care or going to a non-network provider and incurring significant out of pocket costs. We thus encourage the Departments to develop access standards that all plans will have to meet to be in compliance with this and other patient protection provisions of the ACA. In addition, we urge the Departments to require out-of-network cost-sharing for preventive services to be no greater than that for other services provided out-of-network.

Optional Full Coverage of Other (Non-Recommended) Preventive Services. The IFR states that health plans are allowed to deny coverage for services that are “not recommended” by the USPSTF. However, AARP urges the Departments to make the

definition of "not recommended" very clear. Preventive services that the USPSTF recommends against are given a Grade D. The IFR therefore should state that health plans are allowed to deny coverage for preventive services given a Grade D by the USPSTF. However, preventive services that have simply not been evaluated by the USPSTF should not be categorically denied coverage without cost-sharing. Unclear language should not to be used as a reason for health plans to cut back on their coverage of preventive services or fail to cover more services in the future.

Value-Based Benefit Designs. As discussed above, the IFR permits health plans to impose enrollee cost-sharing for recommended preventive services that are obtained out of network. The IFR's preamble references the importance of value-based insurance designs and invites comments to assist the Departments in developing additional guidelines regarding the utilization of value-based insurance designs to promotes consumer choice of high value providers or services, "while ensuring access to critical, evidence-based preventive services." Value-based insurance design is not defined in the IFR.

AARP is concerned that the ambiguity around value-based insurance design could permit plans to impose additional barriers to access to preventive services, e.g. a voucher program. Section 2713 has established a process by which a select group of entities use clinical evidence to determine which preventive services merit 100% coverage. This is already an example of value-based benefit design and we do not believe that health plans require further discretion to vary cost-sharing, provider access, or medical management techniques that could lead to the reduction of full coverage for preventive services. At the very least, the Departments should add a clear definition of value-based insurance design as well as a reference, such as the University of Michigan Center for Value-Based Insurance Design.

Thank you for the opportunity to comment on this important issue. If you have any questions, please feel free to contact Nora Super of our Federal Government Relations staff at (202) 434-3770.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Relations and Advocacy