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Requirement for Group Health Plans and Health Insurance Issuers to Provide Coverage of Preventive Services under the Patient Protection and Affordable Care Act

Comment On: IRS-2010-0017-0001

Requirement for Group Health Plans and Health Insurance Issuers to Provide Coverage of Preventive Services under the Patient Protection and Affordable Care Act

Document: IRS-2010-0017-0037

Comment on FR Doc # 2010-17243

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Organization: National Coordinating Committee for Multiemployer Plans (NCCMP)

General Comment

I received a message from Regina Johnson indicating that our earlier submission failed to include the indicated attachment and requested that we resubmit.

Please see the attached.

Randy G. DeFrehn

Attachments

IRS-2010-0017-0037.1: Comment on FR Doc # 2010-17243

NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Submitted electronically via [Regulations.gov](http://www.Regulations.gov)

September 17, 2010

The Honorable Phyllis Borzi
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Room S-2524
Washington, D.C. 20210

Re: RIN 1210-AB44

Dear Ms. Borzi:

The National The National Coordinating Committee for Multiemployer Plans (the NCCMP) is pleased to provide these comments on the interim final rule implementing the preventive care requirements of the Patient Protection and Affordable Care Act published by the Departments of Labor, Treasury, and Health and Human Services (the “Departments” or the “agencies”) on July 19, 2010.

As you know, the NCCMP is the only national organization devoted exclusively to protecting the interests of the approximately twenty-six million workers, retirees, and their families who rely on multiemployer plans for health and welfare benefits. The NCCMP’s purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit, non-partisan organization, with members, plans, and plan sponsors in every major segment of the multiemployer plan universe, including in the airline, building and construction, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service and trucking industries.

Plan Sponsor Flexibility to Provide Preventive Benefits In-Network and Subject to Plan Medical Management is Important to Preserve

In preparing these comments, we would like to elaborate on some of the implementation concerns applicable to multiemployer plans, particularly those that are self-insured and self-administered. However, we would also like to take this opportunity to commend the Departments on the provisions in the regulation that provide flexibility to plan sponsors that will allow them to design a cost-effective, quality-based plan design.

The Interim Final Rule permits plan sponsors to promote quality and cost-effective preventive services by eliminating cost-sharing for in-network preventive services, but allowing cost-sharing for these services if they are delivered by an out-of-network health care provider. We commend this provision and believe that it is necessary to control costs and to promote higher quality care. Some plan sponsors promote preventive care benefits through plan-sponsored health clinics, or contract with a specific provider network or facility for certain preventive care benefits. These programs are often long-standing and are used to encourage plan participants to receive preventive care services in a quality environment, but also allow the plan to assure that delivery of the services is cost-effective. These practices need to be allowed to continue if plans are to develop the value-based services the Departments encourage.

In addition, the regulation provides that if a guideline does not specify the frequency, method, treatment, or setting for the service, the plan can use reasonable medical management techniques to determine coverage limitations. It is important to allow plan sponsors to determine the terms of coverage, particularly if the recommendation itself is silent on the matter.

This flexibility also permits plan sponsors to continue to maintain programs designed to address fraud and abuse in billing practices by health care providers. Plan sponsors often establish rules to address health care provider billing practices beyond clinically appropriate services. It is important to assure that charges are appropriate and within the recommendations, particularly to avoid services for patients that do not fit within the risk categories and would not benefit from the services (e.g., smoking cessation intervention would not be appropriate for a non-smoker). The regulation did not address whether a provider can unbundle billing for an array of services within the office “wellness visit” or bill each item separately with a new Current Procedural Terminology (CPT) code. Without some controls, we could see an inappropriate level of billing for preventive services that are not needed for some patients. This potential issue speaks to the possible advantage of direct contracting with community providers on a fixed fee or capitated basis for their participants to avoid this unbundling fee-for-service possibility.

Further Guidance Requested

We believe that further guidance may be necessary in additional areas related to the plan’s payment methodologies and standards.

Additional Clarity on Recommendations: Multiemployer health plans typically cover a range of preventive benefits. It is common for screenings, laboratory work, and physical examinations to be covered by the plan either in full or with minimal cost-sharing by the participant. However, the coverage rules tend to be more general coverage requirements, e.g., an annual physical. It is often difficult to match the list of services covered by the plan against the list of services required by the US Preventive Services Task Force (USPSTF); in part because the USPSTF list is not designed to reflect payment rules and conditions but rather reflects treatment recommendations for medical professionals. Consequently, it is challenging to implement the preventive care requirements because of the difference between the language in the recommendations and the commonly used terms of a health benefit plan. We request that the agencies consider providing model plan document language concerning the minimum preventive standards applicable to group health plans and give due consideration to these differences.

Assurance regarding services applicable to certain age groups: We request that the Departments clarify that age-denominated services for children are only required to be provided free for children in the age groups for which they are specifically recommended. The questions have arisen in the context of the age-26 coverage regulation, which prohibits benefit differences between children based on age. We believe that the intent of that particular requirement was to prevent differential treatment between children under age 19 (for example) and those young adults age 19 and over. We do not think that the intent is to require pediatric coverage, such as well-child visits, for children up to age 26, when the preventive services recommendations only require coverage for younger children.

Clarify that plans are not required to cover diagnostic services: It is important to clarify that plans are only required to cover the services listed in the recommendations, and are not required to cover treatment related to the preventive services, even if the treatment is provided at the same time as the preventive service. The plan sponsor should be able to have the discretion to determine whether a service is preventive or treatment. Similarly, plans should not be required to cover the treatments that are identified in the preventive services recommendations (e.g., the plan is required to cover the cost of breast cancer chemoprevention counseling for women at higher risk, but it is not required to cover the chemoprevention therapy itself).

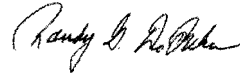
Coverage for Preventive Medicines and Drugs

The Departments have stated in informal presentations that they have not yet determined whether plans must cover over-the-counter medications discussed in the recommendations, or whether they must cover only the counseling relating to use of these medications. These medications could include aspirin, folic acid, iron, fluoride (generally prescription) and smoking cessation interventions (both over the counter and prescription). The Departments have made clear, however, in both oral statements and in IRS Notice 2010-59, that if an over-the-counter medication or drug is covered under an employer-sponsored health plan, the individual must provide a prescription for the medication or drug. However, the Departments have not clarified whether the plan must pay for the medication or just the counseling visit with the health care provider.

Guidance on what types of medicines and drugs are covered under the preventive services rules would be helpful. In addition, the Departments should consider the impact of requiring coverage for over-the-counter medicines on plans that may not currently have a mechanism for reimbursement of over-the-counter drugs. Many multiemployer plans do not have flexible spending arrangements or health reimbursement arrangements, and do not have a process for either providing reimbursements for over-the-counter drugs or for substantiating that the individual had a prescription for the drug. The administrative burdens of implementing both the over-the-counter preventive benefit and the prescription requirement would be difficult for plans that have not offered these types of benefits.

Thank you for the opportunity to provide comments on this important issue. We welcome any questions you may have regarding these suggestions and will be pleased to provide any additional information that you might find useful.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Randy G. DeFrehn". The signature is written in a cursive style with a large initial 'R'.

Randy G. DeFrehn
Executive Director