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

Comment On: IRS-2010-0017-0002
Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services; etc.

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Comment on FR Doc # 2010-17242

Submitter Information

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General Comment

See attached file(s)

Attachments

IRS-2010-0017-0008.1: Comment on FR Doc # 2010-17242

AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

September 17, 2010

The Honorable Kathleen Sebelius
Secretary
c/o Office of Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
P.O. Box 8016
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Dear Secretary Sebelius:

I submit these comments on behalf of the American Psychological Association ("APA" or "we"), the largest membership association of psychologists with more than 150,000 members and affiliates engaged in the practice, research, and teaching of psychology, pursuant the interim final rules for group health plans and health insurance issuers related to coverage of preventive services under the Patient Protection and Affordable Care Act ("PPACA"), as published in the July 19, 2010 Federal Register (75 Fed. Reg. 41,726 et seq.). The APA advocated for required health plan coverage of preventive health services during Congressional consideration of PPACA, and we were pleased to see inclusion in the new law of section 2713, a provision added to the Public Health Service Act to mandate such coverage and which your agency and the other agencies implement with this rulemaking.

The APA fully supports the range of preventive items and services, immunizations, and targeted care and screenings for women and children in section 2713. Many of our members, for example, provide the evidence-based items and services with an 'A' or 'B' rating the current United States Preventive Services Task Force ("USPSTF") recommendations, including counseling for alcohol misuse, screenings for depression in adults and adolescents, screening and counseling for adult and child obesity, counseling for sexually transmitted infections, and counseling for tobacco use ("tobacco cessation") for adults and pregnant women. Health plan coverage for these services will greatly improve the health of plan enrollees.

We focus our comments specifically on the tobacco cessation preventive items and services, included in the USPSTF recommendations as 'A' rated services. Tobacco use takes a devastating toll on our nation's health and economy. Tobacco-related disease causes more than 400,000 deaths and $96 billion in health care costs each year. (See http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a3.htm.) Considering this impact, mandating tobacco cessation prevention coverage is critical to the health of individuals enrolled in health plans.

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The USPSTF tobacco cessation recommendations refer to the clinical practice guideline *Treating Tobacco Use and Dependence* ("guideline"), which is the result of rigorous review of the scientific literature on tobacco cessation and includes a comprehensive summary of evidence regarding interventions. We agree with the straightforward implementation of the tobacco cessation prevention recommendation, as required by the statutory language of section 2713, to require coverage for the individual, group and proactive telephone counseling, as well as the for the FDA-approved medications for tobacco addiction.

We believe, however, that the regulation should be more specific regarding a minimum tobacco cessation benefit that a health plan must provide. The USPSTF tobacco cessation recommendation and guideline are designed as a minimum public health intervention, which is different from a minimum benefit coverage requirement for health plans. A minimum plan benefits coverage requirement therefore should ensure that enrollees have access to (in this case) tobacco cessation services that truly help them quit tobacco use.

As the guideline indicates, there exists a strong dose-response relationship between frequency and length of counseling session; more and longer sessions improve quit rates. Having discussed a minimum benefit with a clinical psychologist who provides these services, we recommend unlimited sessions of high intensity counseling. High intensity counseling would be 30-60 minutes of individual and 60-90 minutes of group counseling. While the guideline specifies high intensity counseling taking far less time, again in a health plan benefit rather than a public health intervention, these longer session times allow a clinical psychologist or other provider to fully address tobacco use issues as they relate to other health issues that the patient may have.

Likewise, with tobacco cessation medications, the regulation should specify that plan enrollees must be provided access to these medications as part of or separately from counseling that may be provided. Regarding both counseling and medication the regulation should specify that a plan may not incorporate barriers to these items and services, such as through prior authorization or other plan management requirements.

Regarding the rule's permitting plan cost-sharing for tobacco cessation services provided by out-of-network providers, such cost-sharing should only be permitted if the plan has licensed behavioral health care providers, or other specially trained providers, available in-network. In addition, even if the plan does have in-network providers, cost-sharing should not be imposed if the enrollee does not have reasonable access to the provider. Therefore, a standard in the rule should be provided that. if an enrollee's place of residence is more than a specified distance away from the nearest in-network provider, say, for example, five miles away, then cost sharing should not be imposed when accessing those services.

Thank you for considering our comments. Please contact Doug Walter, Legislative & Regulatory Counsel, Government Relations, at dwalter@apa.org or at (202) 336-5889, if you have any questions or would like further information.

Sincerely,

Katherine C. Nordal, PhD

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