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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.

Document: IRS-2010-0017-0013
Comment on FR Doc # 2010-17242

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General Comment

See attached file(s)

Attachments

IRS-2010-0017-0013.1: Comment on FR Doc # 2010-17242

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September 17, 2010

Secretary Hilda Solis, Department of Labor
Secretary Timothy Geithner, Department of the Treasury
Secretary Kathleen Sebelius, Department of Health & Human Services
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 D.C. 20210

Re: *Interim Final Rules — RIN 1210-AB44*

Dear Secretaries Solis, Geithner and Sebelius:

Community Health Councils writes to share our recommendations on the Interim Final Rules relating to the coverage of preventive services under the Patient Protection and Affordable Care Act. Community Health Councils is a community-based health promotion, policy and advocacy organization based in South Los Angeles working to improve the health and well-being of low-income communities. We attribute the high rates of health disparities in racial and ethnic populations across this country, and the poorer health outcomes compared to other industrial nations, to the lack of adequate investment in and access to preventive services. We are pleased the interim final regulations seek to address this lack of access to and underutilization of essential preventive services. The new set of patient protections requires health plans and health insurance issuers to cover recommended preventive services without a share-of-cost to enrollees. Although the regulations make significant progress towards eliminating barriers to prevention services, further specificity, accountability and consumer protections should be incorporated to protect against weak interpretations and eliminate potential loopholes in the regulations. Our recommendations are as follows.

1. **Adopt accountability measures for agencies recommending covered preventive services.** The preventive services to be covered with no cost-sharing under the new regulations are set forth by the United States Preventive Services Task Forces (USPSTF), Advisory Committee on Immunization Practices (ACIP) and the Health Resource and Services Administration (HRSA). Recommendations from the USPSTF, the ACIP, and HRSA should consider and be consistent with the evidence-based guidelines developed by experts such as seasoned health organizations and professional medical societies; incorporate findings from comparative effectiveness research; and reflect innovations in the efficient delivery of services. Moreover, the recommendations for preventive service guidelines should be developed in a transparent manner and create sufficient flexibility to cover preventive services based on varying patient risk-factors. Performance against these standards should be publicly reported and incorporated into a system of performance based payments by CMS.

2. **Provide opportunities for expanded stakeholder input.** As a result of the new responsibilities assumed by the USPSTF, ACIP, and HRSA with regard to the coverage of preventive benefits, the regulations must address issues related to the transparency and inclusion of this new decision-making process. Therefore, we urge the Department to create a clinical prevention stakeholders' advisory board

comprised of consumer and patient groups, similar to that created in the House health care bill to provide recommendations for clinical preventive services to the Task Force. Additionally, in the case of the USPSTF, it is critical that the membership be expanded beyond the traditional base of primary care clinicians to include recognized and appropriately credentialed experts on the specific disease states that the services are intended to prevent or detect. Although the final health care reform measure does not require increased membership on the USPSTF, nor does it create an advisory body to secure additional input from patient and consumer groups, the language appears to be broad enough to accommodate such changes made through regulation.

3. **Translate broad preventive service recommendations into a clear set of clinical services to be covered.** The recommendations on preventive services are not always explicitly defined, particularly when the benefits include counseling and other interventions. Therefore, the preventive benefits to be covered based on the current and future recommendations must be clearly specified by the Department of Health and Human Services (HHS) and then by health plans and issuers to ensure patients and providers clearly understand the coverage they have. The process for developing these specific benefits should additionally be designed to incorporate input from groups that develop guidelines in relevant areas. HHS should develop preventive services definitions and standardized coverage language for plans to incorporate into their summary of benefits and coverage to ensure enrollees have a minimum level of access to appropriate, evidence-based preventive services. Most importantly, it should be clarified that the recommendations for preventive services from the responsible agencies should be used as a floor and not a ceiling for covered preventive services by plans and issuers.

4. **Provide coverage beyond the traditional preventive services.** It is our sincere hope that the definition of preventive services will go beyond the conventional health screenings, immunizations and health education programs to include the provision and payment of evidenced based practices for the management of chronic illness. We have seen millions of patients suffering from chronic heart disease with the quality of their care compromised and having to undergo preventable readmissions to hospitals simply because Medicare and other health plans will not pay for cardiac rehabilitation or congestive heart programs. The provision of these services will not only prevent unnecessary suffering but achieve significant savings in health care cost.

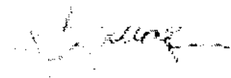
5. **Provide adequate patient notification of covered preventive services.** HHS should require all plans to extensively notify enrollees of what constitutes a covered preventive service. Patients should be notified about how frequently a service can be obtained and still be free of charge and the limitations on free preventive coverage based on patient characteristics such as minimum age. Insurers and health plans should be required to communicate clear and specific information on preventive benefits through a variety of mechanisms, such as certified mail, websites, and in response to consumer inquiries at customer assistance centers. In addition, this information should be available in multiple languages, at an appropriate reading level for public education and in other formats for visually and hearing impaired patients.

6. **Prevent unfair cost-sharing loop-holes related to billing methods.** The current regulations allow health plans and issuers to charge a share of cost for an office visit depending on how the provider bills the visit and reason for the visit. If the preventive services are not the "primary" reason for the visit or if the preventive services are billed separately a plan or issuer may charge the patient for the office visit. This creates incentives to record the primary cause of visit other than preventive services or to bill preventive services separately in order to collect payment for the visit. Such non-transparent mechanisms provide potential opportunities for harmful consumer abuse and are in direct conflict to the intent of the legislation. We therefore urge the Department to prohibit any cost-sharing associated with a visit where preventive services were received or at minimum put in place increased consumer protections to prevent abuse of the regulations. In addition, health plans make a distinction between "share of cost and "deductibles". It is important that the regulations make it clear that the preventative services are also outside of the enrollee's deductible requirements.

The implementation of the Patient Protection and Affordable Care Act provides exciting yet challenging opportunities for administrators, officials and stakeholders across the nation. Community Health Councils is looking forward to working with you to build upon the strengths of our current healthcare system and to make needed reforms to improve quality, access, and affordability of care for children and families.

Should you require additional information or have any questions, please feel free to contact Laura Ewing, Policy Analyst, at 323.295.9372 extension 228.

Respectfully submitted,



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