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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-2010-0017-0002

Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services; etc.

Document: IRS-2010-0017-0021

Comment on FR Doc # 2010-17242

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Washington, DC, 20005**Email:** Jennifer.Boyer@WellPoint.com**Phone:** 202-628-7831**Fax:** 202-638-1096**Organization:** WellPoint, Inc.

General Comment

Dear Secretary Sebelius:

WellPoint Inc. (WellPoint) appreciates the opportunity to respond to 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" (ACA) published July 19, 2010. We understand the important role access to preventive services plays in empowering our members to take care of their health. We look forward to working with the Departments of Health and Human Services (HHS), Labor (DOL), and Treasury (Treasury) to successfully implement these reforms.

WellPoint is the largest publicly traded commercial health benefits company in terms of membership in the United States with 33.8 million medical members at March 31, 2010, and 1.1 million Medicare enrollees. WellPoint is an independent licensee of the Blue Cross Blue Shield Association and serves its members as the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as Blue Cross Blue Shield in 10 New York City metropolitan counties and as Blue Cross or Blue Cross Blue Shield in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs

of Washington, D.C.), and Wisconsin; and UniCare Life and Health nationwide.

WellPoint appreciates this opportunity to offer our suggestions for implementation of the preventive services regulation. Should you have any questions or wish to discuss our comments further, please contact Jennifer Boyer at 202-628-7831 or Jennifer.Boyer@WellPoint.com.

Sincerely,

Elizabeth P. Hall
Vice President, Public Policy

Attachments

IRS-2010-0017-0021.1: Comment on FR Doc # 2010-17242



655 15th Street, NW
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Elizabeth P. Hall
Vice President
Public Policy

Submitted via Federal e-Rulemaking Portal: www.regulations.gov

September 17, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

ATTENTION: OCIIO-9992-IFC

RE: Coverage of Preventive Services

Dear Secretary Sebelius:

WellPoint Inc. (WellPoint) appreciates the opportunity to respond to 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" (ACA) published July 19, 2010. We understand the important role access to preventive services plays in empowering our members to take care of their health. We look forward to working with the Departments of Health and Human Services (HHS), Labor (DOL), and Treasury (Treasury) to successfully implement these reforms.

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Overview

WellPoint is dedicated to the health and well being of our members, and we share the Departments' commitment to ensuring appropriate access to preventive health services for our members. Provider networks are an important tool for facilitating patient access to, and

utilization of, appropriate and effective preventive services, and we appreciate that the IFR acknowledges the value of these networks.

While the IFR makes important strides, we are concerned that it requires plans to use clinical guidelines – developed to assist practitioners care for patients – to make coverage determinations. Guidelines typically include far less specificity than coverage policies require, and thus, plans may need to make good faith assumptions to comply, absent further direction from the Departments. To that end, we ask that the Departments take into account good faith efforts to comply with the provisions of the rule, particularly as the effective date for plan or policy years beginning on or after September 23, 2010, is six calendar days after relevant comments must be submitted to the Departments.

These recommendations and others are further reflected in our comments below.

Use of Clinical Guidelines as a Coverage Tool

The ACA and this IFR state that non-grandfathered individual and group health plans must provide coverage with zero cost sharing for preventive services that are current recommendations of the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA). While WellPoint recognizes that the ACA explicitly incorporates these entities' recommendations as part of the preventive services requirements, we wish to point out that guidelines developed by entities such as the USPSTF, HRSA, and CDC are, by design, for clinicians to guide clinical practice. The broad guidelines from these entities are used to steer the decision making for coverage guidelines but should not be expected to provide enough guidance to make concrete coverage decisions that can be used to adjudicate coverage. WellPoint requests that the Department allow enough flexibility for the best interpretations of the guidelines as they would be implemented as coverage guidelines.

Office Visits and Cost Sharing

Like other plans and issuers, WellPoint applies cost sharing to office visits, procedures, and services based on the provider's account of the member's visit. We rely on providers to code correctly to ensure the primary purpose of a member's visit is captured, and this dynamic will not change as a result of either the ACA or the IFR. The IFR states that plans and issuers may apply cost sharing to office visits where mandatory, zero cost sharing preventive services are delivered if the preventive service is billed separately, or if the primary purpose of the office visit is for a reason unrelated to the preventive service provided. Just as we do today, WellPoint will continue to determine cost sharing applicability by relying on provider coding to determine the purpose of an office visit and will educate our members that the decision to code the primary and secondary purposes of an office visit is based upon the opinion and expertise of that particular provider. We appreciate the Departments' acknowledgement in the IFR preamble that prohibiting cost sharing for office visits when any recommended preventive service is provided, regardless of the primary purpose of the visit, could lead to an overly broad application of the zero cost sharing provisions, which would consequently lead to increased premiums for members. However, notwithstanding the preamble acknowledgement, we remain concerned that the zero cost sharing provisions will lead to inappropriate increases in the application of zero cost sharing to office visits. Therefore, we ask the Departments to set or maintain a reasonableness standard that will allow plans and issuers to work in concert with them and other relevant stakeholders to prevent the misuse of the zero cost sharing provisions.

Out-of-Network Providers

Well-designed provider networks promote efficient, cost effective care, offering value to both the member and the provider. WellPoint appreciates that the Departments recognize this value and that the IFR does not require a plan or issuer to provide coverage for preventive services delivered by an out-of-network provider, and permits plans that allow the use of out-of-network providers to apply cost sharing to covered preventive services. However, WellPoint recommends that the Departments also permit plans to apply cost sharing to preventive services delivered by providers in non-preferred network tiers. Without such modification, this policy could have a detrimental impact on value-based insurance designs. For example, many health plans have tiers within a network of providers that are meant to promote member utilization of the highest-quality providers. Differentiated cost sharing by tier is one of the tools that plans use to drive member and provider behavior in such plans. In those instances, plans will have to cover at zero cost sharing preventive services delivered by any in-network provider, regardless of tier, thus undermining the quality-based incentive structure that has been constructed by the plan or issuer.

Reasonable Medical Management

WellPoint appreciates that the Departments recognize and permit plans and issuers to use reasonable medical management techniques when determining appropriate preventive services coverage.

Changes in Recommendations or Guidelines

Health insurance issuers and health plans often make changes in the course of normal business to ensure covered services reflect advances in clinical knowledge and technologies. Examples of such changes include making modifications to medical policy as new evidence becomes available about the safety and efficacy of treatments, and revising formularies when new products, such as drugs with improved risk profiles or more affordable generic alternatives become available. In that vein, plans will update coverage and cost sharing for preventive services when a recommendation or guideline no longer meets the criteria set by the ACA and this IFR (e.g., a "B" recommendation is downgraded to a "D" recommendation).

We ask that the Departments specify that a modification of benefits (e.g., changes to coverage or cost sharing) made when a preventive service no longer meets the ACA and IFR criteria does not constitute a material modification to the plan with respect to grandfathered status. While grandfathered plans are not required to comply with this IFR, many plans already do cover, or may choose to newly cover, some or all of the preventive services identified in this rule at no cost to members. In the event that a service no longer meets the criteria for coverage under this IFR, we ask that the Departments permit plans to terminate coverage or institute cost sharing for those services without piercing grandfathered status. Rather, such changes should be considered like any others made in the normal course of business to promote quality care.

Impact on Premiums

We commend the Department for conducting an analysis to determine the potential impact the preventive services requirements will have on premiums. WellPoint's own internal analysis of the group market is in line with the Department's 1.5% estimated increase in premiums. However, we caution that while group plans are relatively uniform in their current coverage of

preventive services, there is far greater volatility across individual plans with respect to the level of preventive services currently afforded. Thus, individuals will see greater variance in the impact of these regulations on premiums.

Value-Based Insurance Design (VBID)

WellPoint applauds the Departments for seeking comments on developing guidelines for value-based insurance designs that promote consumer choice, care quality, and access to effective preventive services. We are encouraged that the Departments have acknowledged the utility of well-designed provider networks as a means of properly incentivizing patients and providers. A requirement for successful VBID is flexibility for issuers and plans to be innovative in plan design. We look forward to sharing expertise and working with the Departments to develop guidance that ensures continued flexibility for VBID.

WellPoint appreciates this opportunity to offer our suggestions for implementation of the preventive services regulation. Should you have any questions or wish to discuss our comments further, please contact Jennifer Boyer at 202-628-7831 or Jennifer.Boyer@WellPoint.com.

Sincerely,



Elizabeth P. Hall
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