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Docket: IRS-2010-0017

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-2010-0017-0035

Comment on FR Doc # 2010-17242

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Attached please find comments from HR Policy Association.

Attachments**IRS-2010-0017-0035.1:** Comment on FR Doc # 2010-17242

September 17, 2010

Submitted Via Federal eRulemaking Portal
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

RE: 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 Sir or Madame:

HR Policy Association (“HR Policy”) is submitting this comment letter on the interim final regulations (regulations) implementing the rules for group health plans and health insurance coverage under provisions of the Patient Protection and Affordable Care Act (PPACA; Public Law 111–148), amended by the Health Care and Education Reconciliation Act (Public Law 111–152) regarding preventive health services. The regulations were issued by the Departments of Labor, Health and Human Services, and Treasury (the “Agencies”) and printed in the Federal Register on July 19, 2010. (75 Fed. Reg. 41726). It is our understanding that these comments will be shared with the Departments of Health and Human Services and Treasury.

HR Policy represents the chief human resource officers of over 300 of the largest employers doing business in the United States. Representing every major industrial sector, HR Policy's members employ more than 18 million people worldwide and collectively spend more than \$75 billion annually providing health insurance to millions of American employees, their dependents and retirees.

Section 2713 of the Public Health Services Act as added by PPACA requires a group health plan and a health insurance issuer to provide coverage benefits for and prohibit the imposition of cost-sharing requirements with respect to certain preventive coverage services. Many of our member companies offer comprehensive health care benefits for their employees and their families, including preventive services. However, in many instances, PPACA and the regulations go beyond the benefits broad benefits that many of our members currently provide.

These comments are submitted with the objective of ensuring PPACA implementation facilitates the ability of employers to continue to offer comprehensive health benefits. This letter focuses on the Agencies' request for input on value-based insurance designs, as well as employers' concerns and need for clarity relating to coverage of treatments and interventions that may be discovered during preventive services, a health plan's flexibility to use medical management techniques, and coverage of drugs under the regulations.

Permitting Continuation of Value-Based Insurance Design for Providing Preventive Coverage

PPACA gives authority to the Agencies to develop guidelines for group health plans and health insurers offering group or individual coverage to utilize value-based insurance designs as part of their offering of preventive health services. The Agencies have asked for feedback on guidelines regarding the utilization of value-based insurance designs by group health plans and health insurance issuers with

respect to preventive benefits. The Association supports the regulations allowance of limiting coverage of preventive services without cost sharing to in-network providers, and believes other allowances for value-based insurance design can achieve the coverage goals of PPACA while permitting health plans to create incentives for delivery of treatments in a manner that delivers the highest quality and efficient care.

Employers use value-based insurance designs in the health plans that they sponsor to encourage the use of high-value care that takes into account the quality of care and its relative costs. These designs have been useful tools in helping employers manage the costs of their health plans and *improving the health* of their employees. Value-based designs employ financial incentives through differential copayments, deductibles, or coinsurance to encourage plan participants to seek cost-effective, high-quality, proven treatments and to discourage the overuse of costly and wasteful treatments. For example, an employer may reduce barriers to care for certain conditions to increase drug compliance and adherence by providing free coverage of cholesterol-lowering medications for beneficiaries with histories of diabetes or heart attacks. Employers may also set higher copayments, cost-sharing, or coinsurance for treatments and facilities that have been proven not to provide high-quality outcomes.

Given that PPACA provides authority for the Agencies to permit the use of value based insurance design in delivering preventive coverage, our members recommend permitting employers to impose reasonable limitations on the coverage of preventive services and make reasonable coverage distinctions for services that are delivered under value-based insurance designs. For example, a plan should be able to provide certain high-value medications with no cost-sharing in order to facilitate compliance with recommended treatments, while continuing to vary cost sharing for other preventive or maintenance classes of drugs. In addition, employers often places incentives for services delivered through “centers of excellence” that deliver the best outcomes for procedures. A health plan may require a plan participant to pay more for services delivered outside of a center of excellence even if it is an in-network provider. This value-based insurance design practice should be permitted under the regulations.

Value-based insurance design is an evolving practice that will change as medical, pharmaceutical, and consumer behavior research evolve. As such, the Association urges the Agencies to provide flexibility in the regulations to reflect the dynamic nature of plan design. In addition, health plans and employers ask the Agencies to provide examples of elements of value-based insurance design in relation to the coverage of preventive services that would be permissible under the regulations.

Clarity with Respect to Maintaining Flexibility to Use Medical Management Techniques

The regulations provide that nothing “prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service” required to be covered to the extent not *specified in the recommendation or guideline*. The Association strongly supports granting plan sponsors this authority and recommends permitting plan sponsors to maintain significant latitude to manage their plans in a way that meets the unique needs of their workforce while providing preventive coverage consistent with PPACA and regulations. However, plan sponsors would greatly benefit from examples to illustrating the scope of this authority and/or provide further clarity that expressly grants plan sponsors broad discretion in this area.

For example, some recommended screenings may be individuals who are at a “high risk” for a specific disease or condition. To the extent the guidelines do not clearly define high risk, a plan sponsor should be able to use evidence-based medicine to make such determinations and limit screenings without cost sharing to high risk individuals as defined under terms of its plan. Otherwise, there could be an incentive for providers to offer the screenings in an inappropriately broad manner to individuals who are not at risk for the condition. Plan sponsors would like examples or clarity from the Agencies that provide

assurance that a plan sponsor can determine the individuals for whom they have to provide screenings without cost sharing and limit coverage to appropriate populations defined under applicable guidelines.

Moreover, some applicable prevention guidelines and recommendations may include a range of suggested preventive services, including counseling, drugs, and/or screenings. In these instances, it is unclear whether a plan sponsor can determine which recommendations to provide without cost sharing.

Plan Sponsors Seek Clarity Regarding Coverage of Drugs

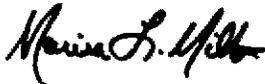
Plan sponsors seek clarification regarding coverage of drugs, particularly over-the-counter (OTC) medications, under the regulations. Currently, many employer health plans do not offer coverage of OTC drugs. However, in some instances, preventive recommendations and guidelines recommend the use of OTC medications for certain populations. For example, preventive guidelines covered by the regulations include aspirin for individuals at risk for heart attack or stroke and folic acid for women of child-bearing years. Plan sponsors need clarity to determine whether they are required to provide without cost sharing aspirin and vitamins with folic acid without vitamins. If so, they need to know if they can limit coverage to a generic OTC drug as they do for other medications provided under their health plans.

In addition, in many instances OTC medications are not excludable from an employee's federal taxable income, and plan sponsors generally do not provide benefits that may be taxable to an employee. Other provisions of PPACA exclude OTC medications from tax preferred reimbursement or coverage. Requiring coverage of OTC medications without cost sharing when it would be taxable to the employee would create confusion for the plan sponsor and the covered individual. Requiring plan sponsors to cover OTC would raise a host of complications. Given the complexity of administering the provision of certain OTC medications, the potential tax consequences, and relatively low costs of many OTC medications, the Association recommends that plan sponsors should not be required to cover OTC drugs that are not required by prescription.

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We appreciate the opportunity to comment on the regulations. If you have any questions, please contact me at mmilton@hrpolicy.org or (202) 789-8671.

Sincerely,



Vice President, Health Care Policy
& Government Relations
HR Policy Association

September 15, 2010
Employee Benefits Security Administration
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