
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 Madam:

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 August 3, 2011. (76 Fed. Reg. 46621). It is our understanding that these comments will be shared with the Departments of Health and Human Services and Treasury.

HR Policy Association represents the chief human resource officers of more than 330 of the largest employers in the United States. Collectively, their companies employ more than 10 million employees in the United States, nearly nine percent of the private sector workforce. Together the member companies spend more than $80 billion annually providing health insurance to tens of millions of American employees, their dependents, and retirees.

At the outset, we note that 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 broad benefits that many of our members currently provide.

These comments are submitted with the objective of ensuring that PPACA’s implementation provides sufficient flexibility and is done in the most cost effective manner in order to preserve the ability of employers to continue to offer comprehensive health benefits. The Association would like to highlight the simple fact that health care costs will continue to increase as the
agencies develop new guidelines and impose additional mandates. While many of these costs will be borne by employers, many will be passed to employees and their dependents (i.e., plan participants) as well. Once again, the Association recommends that the agencies keep this in mind as they formulate future guidelines.

**The Health Resources and Services Administration New Guidelines for Women’s Preventative Services**

Under the interim final regulations, the Health Resources and Services Administration (HRSA) are charged with developing guidelines on preventative care for women. The Association is filing these comments in response to HRSA’s issuance of “Women’s Preventative Services: Required Health Plan Coverage Guidelines.” The comments include specific recommendations and requests for clarification on particular issues regarding the new guidelines.

The interim final 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 guidelines. 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 more examples that would illustrate the scope of this authority and/or provide further clarity that expressly grants plan sponsors discretion in this area.

**Out-of-Network Preventive Services.** There have been some questions raised whether the rule in the interim final regulations allowing the limiting of coverage of preventative services without cost sharing to in-network providers would apply to those services set forth in the new guidelines. Many plan sponsors recommend that the rule allowing cost sharing for preventative services for out-of-network providers apply to the new guidelines.

**Screening and Counseling for Interpersonal and Domestic Violence.** The new guidelines also provide for an “annual” screening and counseling for interpersonal and domestic violence. Given that this is an annual screening or service and the term “counseling” denotes more frequent visits, plan sponsors are seeking clarification regarding the no cost preventative services or procedures that would fall within the meaning of “screening and counseling for interpersonal and domestic violence.” Would such services be performed by an individual’s primary care physician or behavioral health specialist? The HHS Fact Sheet on this issue only mentions that “screening” is an effective early detection tool. (Affordable Care Act Rules on Expanding Access to Preventative Services for Women, as visited September 29, 2011). More guidance is needed to determine what services or procedures will be treated as no cost services so that plans can treat them appropriately under their billing and reimbursement systems.

**Contraceptive Methods and Counseling.** Plan sponsors seek clarification regarding what “sterilization procedures” would be deemed a no cost preventative service. For example, some procedures, such as tubal ligation, would be considered a major surgery and would generally not
be recommended as a preventative measure. More guidance is needed in this area so plans can better comply.

Moreover, further guidance is needed regarding no cost preventative services that may be considered “contraceptive methods.” Contraceptives are available in a variety of methods at widely varying costs (see http://www.ncbi.nlm.nih.gov/pubmed/6671479). But there is no clear guidance on this point. According to the HHS Fact Sheet on expanding contraceptives to women plans will “retain flexibility to control costs and promote efficient delivery of care by, for example, continuing to charge cost sharing for branded drugs if a generic version is available and just as effective and safe.” (Affordable Care Act Rules on Expanding Access to Preventative Services for Women). However, the guidelines provide that “all [FDA] approved contraceptive methods” would be subject to no cost preventative services. Clearly, there is ambiguity on this point that needs to be resolved. Plan sponsors recommend careful consideration of contraceptive effectiveness, safety, and cost in identifying the contraceptive methods to be included in the new guidelines.

Plan sponsors also question whether no cost preventative services would include over-the-counter contraceptives, particularly if such items are not “qualified medical expenses” under Section 213 of the Internal Revenue Code. Moreover, requiring plan sponsors to cover over-the-counter drugs/items would raise a host of administrative complications.

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We appreciate the opportunity to comment on HRSA’s guidelines. If the Association can be of further assistance, please contact Michael Peterson at 202-789-8659 or mpeterson@hrpolicy.org.

Sincerely,

Michael Peterson
Vice President, Benefits & Employment Policy
Associate General Counsel
HR Policy Association