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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

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Government Agency Type: Local

General Comment

See attached file(s)

Attachments

IRS-2010-0017-0025.1: Comment on FR Doc # 2010-17242

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Thomas A. Farley, MD, MPH
Commissioner

Health

September 17, 2010

http://www.regulations.gov

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
(file code OCIIO-9992-IFC)

To Whom It May Concern:

The New York City Department of Health and Mental Hygiene (DOHMH) welcomes the opportunity to comment on the above referenced interim final rules.

The Introduction indicates that there have been attempts to estimate the increase in average benefits and premiums in the group health plan and individual market, as a result of eliminating cost-sharing and increasing covered services. In particular, in Section 5 *Costs and Transfers,* the following is stated: "... costs that were previously paid out-of-pocket for certain preventive services will now be covered by plans and issuers under these interim final regulations. Such a transfer of costs could be expected to lead to an increase in premiums." The Departments have estimated that the regulations will result in a $4 per-person annual increase in insurance benefits and a 1.5% increase in premiums for enrollees in non-grandfathered plans. DOHMH urges that the Departments more explicitly address the issue of how providers will be made financially whole when providing covered preventive services, in light of the transfer of costs described. Addressing this issue is critical to ensuring that the regulations do not result in a provider disincentive to provide preventive services.

§54.9815-2713T (a)(2)(iv) ; Example 3

Although the conclusion of Example 3 is appropriate, the underlying principle (*If the primary purpose of the office visit is the delivery of an item or service described in paragraph (a)(1), a plan may not impose cost-sharing requirements*) may be subject to abuse. That is, cost sharing could be inappropriately avoided by simply stating that the primary purpose of the visit is the delivery of an item or service described in paragraph (a)(1) and which is not billed separately.

To illustrate, in the published Example 3, a patient could state that the office visit was for a blood pressure screening but then mention the problem of recurring abdominal pain in response to any general inquiry by the provider. According to the guidelines provided, in such a scenario, the plan would not be able to impose cost sharing.

Although (a)(4) permits plans to apply "reasonable medical management" techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) to

than determined by the insurer. In such a case, either the patient cannot avoid cost-sharing for a preventive service (which is both unfair and contrary to the intention of the Affordable Care Act), or, the provider must be willing to absorb the administrative burden of convincing the insurer that the office visit was in fact a bona fide visit for a paragraph (a)(1) service.

The same concerns would apply to Sections 2590.715–2713 and 147.130.

We appreciate the opportunity to provide our comments regarding these interim final rules.

Sincerely,

Thomas Merrill
General Counsel

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