National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

December 4, 2023

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Avenue SW
Washington, DC 20024

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

The Honorable Julie Su
Acting Secretary of Labor
200 Constitution Ave NW
Washington, DC 20210

Dear Secretaries Becerra, Yellen, and Su:

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), an association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. We are pleased to have the opportunity to provide answers to the questions posed in the "Request for Information; Coverage of Over-the-Counter Preventive Services" that was published in the *Federal Register* on October 5, 2023.

The members of NABIP work daily to help millions of people and businesses purchase, administer and utilize health insurance coverage. We have direct experience with plan design and preventive care coverage. NABIP members who specialize in individual and group coverage, pharmacy benefit coverage, and plan design and administration provided their direct expertise to inform our responses to each question. We truly appreciate the opportunity to provide this feedback, and our association is very committed to ensuring equitable access to healthcare generally and preventive care specifically.

A. Access to and Utilization of OTC Preventive Products

1. What is the current cost differential for consumers between an OTC preventive product purchased without a prescription by a healthcare provider and the same OTC preventive product (for example, breast pumps and breastfeeding supplies) when it is prescribed? How common is it for plans and issuers to provide coverage for OTC preventive products without requiring a prescription by a healthcare provider? Share any available measurements of utilization of coverage for OTC preventive products when prescribed and when not prescribed by a healthcare provider.

The out-of-pocket cost differential for individuals who purchase a preventive product out of pocket versus the cost for consumers who have a prescription and are able to purchase this product using their health insurance benefits depends on the cost of the actual OTC product. Folic acid, which is used for

preventive reason during pregnancy would be around $10, whereas an electric breast pump would be well over $100.

It is not at all common for health plans and issuers to provide coverage of OTC preventive products without a prescription. Therefore, NABIP members do not believe that there is credible data available outlining the utilization of OTC products considered to be preventive care that were purchased by insured individuals using out-of-pocket funds versus the utilization of such products when covered by insurance due to the existence of a prescription.

2. When coverage is offered for OTC preventive products that are prescribed by a healthcare provider, do cost sharing or other aspects of coverage vary by type of OTC preventive product? For example, are different cost-sharing requirements or medical-management techniques imposed for OTC tobacco-cessation products than for OTC breast pumps? Do coverage requirements or medical-management techniques differ across different types of OTC contraceptives, such as between emergency contraception and condoms, or between medications and devices? What medical-management techniques do plans and issuers commonly apply to OTC preventive products when the items are prescribed? If plans and issuers impose quantity and/or frequency limits or establish brand preferences for equivalent products, how do they determine such limits and preferences?

When coverage is offered for any OTC preventive products that are prescribed by a healthcare provider, there will be no cost-sharing if the prescription is filled by an in-network source since preventive services must be covered on a first-dollar basis. However, depending on what the OTC preventive product is, then medical management may vary because sometimes the product in question might be a prescription drug, and others it would be considered a medical device or durable medical equipment. Coverage of these services is typical handled by different entities (PBM versus the medical plan), therefore utilization-management practices will differ. For example, quantity limits would be much different for a medication than a medical device. Plans determine quantity limits and other medical-management practices for OTC preventive items in the same way they do for preventive medications and devices that are not available OTC, based on medical necessity, safety and appropriateness.

For preventive products that are considered to be medical devices or durable medical equipment, such a breast pump, generally, individuals seeking coverage of these items are directed to a vendor selected by the plan and are required to order these items via website or telephone. The items available include commercial-grade products and items that are commonly available through a retail pharmacy. If an individual elects to use a different source for purchasing and submits a claim for a prescribed OTC preventive product after the point of purchase, the process is much more complicated. First, in many cases, these post-claim reimbursement submissions are the result of purchases at a non-participating provider, so cost-sharing would likely apply. Further, since pharmacy receipts are not the same as a typical receipt from a provider for medical services, they do not typically have appropriate coding.

Therefore, they are much more difficult for plans to process.

3. How does a plan's or issuer's practice of covering OTC preventive products only when prescribed by a healthcare provider affect individuals' access to OTC preventive products? What other

practices (for example, reasonable medical management techniques, network restrictions or formulary restrictions) are employed by plans and issuers that restrict access to recommended preventive products that are available OTC?

Concerning plan practices today, most plans include at least some degree of network or preferred provider requirements regarding the coverage of pharmaceuticals, medical devices and durable medical equipment generally, and these extend to such products and medications that are considered to be preventive care. Regarding formulary restrictions, a very limited number of self-funded plans do attempt to limit formulary access to medications that are generally available OTC. However, this is not a particularly common practice, and it does not typically affect medications and items that might be considered preventive care. It is more commonly directed at medications like pain killers that are readily available OTC.

4. If the Departments were to require plans and issuers to cover OTC preventive products without cost sharing and without a prescription by a healthcare provider, what would be optimal ways to communicate these changes to help ensure that participants, beneficiaries and enrollees are educated about any steps they need to take to access these products, including to get reimbursed for purchasing OTC preventive products without a prescription by a healthcare provider? Similarly, what would be optimal ways to communicate the changes to retailers?

The optimal way these changes and related educational information could be communicated to participants, beneficiaries and enrollees would be through health insurance agents and brokers and employers during open enrollment. Based on experienced gleaned by the coverage requirements for OTC COVID-19 tests, communication available to participants, beneficiaries and enrollees at retailers is likely to be inconsistent and not extensive. Signage within the stores is the most likely source of retail-level communication, and it is important to keep in mind that if an individual goes to a non-pharmacy register, then a retail store is unlikely to be able to process a preventive care claim and the individual will be charged the retail price of the product.

B. Implementation Issues

1. In the event that the Departments require plans and issuers to cover OTC preventive products without cost sharing and without requiring a prescription by a healthcare provider under section 2713 of the PHS Act, what operational challenges would plans and issuers face in implementing the requirement? What operational challenges would retailers (including pharmacies) face if the requirement is implemented (for example, location of transaction, privacy concerns or workload at point of sale)? How would these challenges impact participants, beneficiaries and enrollees? How would these challenges impact the goal of E.O. 14101 to increase access to affordable contraception? What operational challenges may be associated with the use of tele-pharmacies and mail orders both within and across states or localities for OTC preventive products?

Significant operational challenges would exist at the retail level and with the submission and processing of retail-level claims. This was very evident during the OTC Covid-19 test first-dollar coverage mandate. A major concern would be that retail establishments typically divide potentially insurer-covered purchases and other OTC purchases between two sets of counters and cash registers. Directing

consumers appropriately and preventing different consumer costs based on which register selected is a known issue. Further, pharmacy and insurer/plan technology and communications would need to be substantially different and better than they are currently. Regarding the processing of these claims, a traditional retail OTC receipt does not include the coding and information needed by a typical health plan claims-processing system. It is possible that technology could be developed and installed similar to what is used to verify HSA- and FSA-eligible OTC purchases, but there would need to be modifications made and it would not be a simple or fully transferrable process.

If this coverage mandate were imposed, then health insurance issuers and group plan sponsors will likely want to limit access to such coverage to specific vendors and mail-order and online sales, as they do with items like breast pumps today. Processing retail OTC claims submitted after the point of purchase will be extraordinarily difficult for plans, as the receipts and documentation of such purchases that exist currently are sufficient for typical claims-processing systems. Further, there is a real question about whether consumers will even submit such receipts and attempt to obtain reimbursement, even if were available. Consumers tend to view these purchases as sunk costs. Based on plan experience with after-purchase reimbursements for things like prescriptions filled on the first few days of a plan year when individuals may not have their ID cards and account information on file with the pharmacy, very few of these claims are actually submitted for post-claim reimbursement.

2. If plans and issuers were required to cover OTC preventive products without cost-sharing and without requiring a prescription by a healthcare provider, how could plans and issuers ensure that participants, beneficiaries and enrollees who purchase OTC preventive products do not incur out-of-pocket costs at the point of sale, or are timely and correctly reimbursed, such as through post-purchase reimbursement by the plan or issuer or other mechanisms? Would utilization rates differ depending on whether the products were covered without cost to the individual at the point of sale or were reimbursed following purchase? Should plans and issuers be required to cover costs associated with shipping and/or taxes for OTC preventive products? What is the best way to eliminate out-of-pocket costs to participants, beneficiaries and enrollees while ensuring that they have different options to obtain such products (such as via direct mail and in person)? What other issues related to consumer reimbursement would arise if plans and issuers were required to cover OTC preventive products without cost-sharing and without a prescription by a healthcare provider?

Addressing the out-of-pocket issue at the retail level would be extraordinarily difficult, as was demonstrated with the coverage of OTC COVID-19 tests. Numerous and largely uncontrollable factors that could lead to out-of-pocket costs at the retailer exist, such as the plan participant purchasing the product at the wrong cash register, or the approved brand product not being in stock at the pharmacy. If plan participants purchase OTC preventive care products online through a preferred plan vendor or through the plan's mail order pharmacy, then it will be much easier to eliminate out-of-pocket costs, as is the case with coverage of breast pumps currently.

It is important to note that, no matter what precautions may be taken, plan participants do pay out-of-pocket costs for preventive care still, even for medical preventive services. For example, individuals come into a doctor's office for well visits and preventive medical tests and are billed incorrectly, or their preventive services are co-mingled with non-preventive medical care expenses for which cost-sharing is

involved. It would be unreasonable to assume one can eliminate out-of-pocket costs at a retail setting, particularly when considering such drastic plan design and reimbursement changes.

Regarding utilization, certainly any service that is available with no up-front costs is utilized at a greater rate than those services that require payment at the time of purchase. OTC preventive care medications and devices would be no different. However, there are serious retail practicality considerations to address, not the least of which will be the need to be able to communicate much more detailed coding information from the retailer to the plan that what is typically included on a retail pharmacy receipt. The HSA/FSA model could be examined as a possible modified solution, but there would need to be significant operational technology changes to make this a reality. Another option would be for plans to provide individuals with a preventive care OTC code QR code or a HCPCS code for preventive care OTC purchases but, again, such a system would involve huge technological and operational investments that would need to evolve with time as technology changes.

As for shielding consumers from sales tax and shipping costs, this would be next to impossible to do at a retail setting. Not only could state revenue and tax issues arise, but also retail pharmacies are not equipped to routinely waive sales tax on certain purchases or partial purchases. That would take special cash register and technological systems, such as those used at a duty-free store. However, if individuals were directed to a mail-order or online ordering system through a preferred vendor, they could probably be shipped the items with no first-dollar expenses.

3. What issues related to reimbursement to retailers and providers would arise if plans and issuers are required to cover OTC preventive products without cost-sharing and without a prescription by a healthcare provider? How might contracts between plans or issuers and PBMs, network pharmacies or other service providers need to be modified to cover OTC preventive products without cost-sharing and without a prescription by a healthcare provider? How do plans and issuers anticipate accounting for any retail markups, discounts or coupons, or manufacturer rebates?

We do not see a way for plans and retailers to develop a reimbursement system whereby a retail pharmacy would front the costs for plan sponsors and issuers for OTC non-prescription products and obtain plan reimbursement later. This was not possible regarding COVID-19 OTC test coverage on a general basis, and we do not believe that pharmacies would be receptive to such a change on a more pervasive level.

4. How do pharmacies or other retailers currently submit claims to plans and issuers for OTC preventive products and are there barriers associated with doing so? If plans and issuers were required to cover OTC preventive products without cost-sharing and without requiring a prescription by a healthcare provider, would pharmacies or other retailers be able to ensure that a consumer does not incur out-of-pocket costs at the point of sale? If not, what barriers prevent this, and would addressing those barriers require changes to claims systems or additional guidance?

Retail pharmacies do not do this typically. Individuals usually need to pay for the product out of pocket and then submit to the plans for reimbursement later. Given that many of these items are low-cost,

most individuals do not submit them for reimbursement, as the pharmacy receipts tend to cause claims problems and reimbursement submission is generally perceived as more trouble than it is worth. As previously stated, if plans and issuers were required to cover OTC preventive products without cost-sharing and without requiring a prescription by a healthcare provider, it would be next to impossible to ensure that plan participants never had to pay out-of-pocket costs. Bringing the current retail environment even close to that scenario would be an enormous and costly technological, operational and education lift for all involved parties. Based on anecdotal observations of purchasing habits related to medications and other products that are now readily available OTC, such as certain cold medications and proton pump inhibitors, NABIP members do not believe that implementing such a change would be ultimately worthwhile either from a cost or increased utilization and access perspective.

5. If plans and issuers were required to cover OTC preventive products without cost-sharing and without requiring a prescription by a healthcare provider, what types of reasonable medical-management techniques related to frequency, method, treatment or setting would plans and issuers consider implementing with respect to these products, in instances where an applicable recommendation or guideline did not specify the frequency, method, treatment or setting for the provision of the recommended preventive service? How would such techniques differ or compare to strategies used currently? What additional guidance would be necessary to help plans and issuers understand what types of medical-management techniques are considered to be reasonable when applied to OTC preventive products?

If plans and issuers were required to cover OTC preventive products without cost-sharing, then NABIP anticipates that plans and issuers will want to impose medical-management techniques by limiting individual purchasers to online or mail-order fulfillment, such as exists today with breast pumps. In a retail setting, there will need to be limitations on the frequency and volume of purchases to make sure that medical safety guidelines and appropriate use is occurring. This might need to be handled at the pharmacy or retail level, similar to how restrictions on products like OTC cold medications or cigarette and alcohol are handled.

6. If plans and issuers were required to cover OTC preventive products without cost-sharing and without requiring a prescription by a healthcare provider, what guardrails would plans and issuers consider implementing to mitigate fraud, waste and abuse?

Regarding abuse of OTC preventive products, this would need to be a public-education effort. Also, fraud, waste and abuse might need to be handled by restricting access in the retail store, such as access is already limited to products like certain cold medications. A plan or issuer would be able to implement more effective fraud, waste and abuse controls if reimbursement of OTC preventive products without a prescription were limited to online or mail-order pharmacy services through specific plan-designated vendors.

7. What operational challenges arose while plans and issuers were required to provide OTC COVID-19 diagnostic tests without cost-sharing and without a prescription or provider involvement during the COVID-19 PHE that were not addressed through guidance issued by the Departments? Were there particular operational challenges experienced by retailers? What lessons learned from those experiences could be applied to efforts to require coverage for OTC

preventive products without cost-sharing and without a prescription by a healthcare provider? Would plans' and issuers' provision of direct coverage for OTC COVID-19 diagnostic tests to participants, beneficiaries and enrollees by providing payments to sellers directly (without requiring upfront payment by consumers and subsequent reimbursement by the plans and issuers) be a model that could be used to implement an OTC coverage requirement for preventive products? The Departments are particularly interested in the experience of consumers, plan sponsors, retailers, plans, issuers, PBMs and other service providers related to techniques that were implemented during the COVID-19 PHE to prevent, detect and respond to fraud, waste and abuse related to the provision of OTC COVID-19 diagnostic tests.

Some of the challenges NABIP members observed during the period COVID-19 OTC tests were covered without a prescription that would need to be address if plans and issuers were required to cover OTC preventive products without cost-sharing include:

- Individuals who did not go to the "correct" registers were charged the full retail price for the tests and had little recourse if they realized their mistake later.
- Rules regarding reimbursement procedures changed multiple times and different types of stakeholders, at all levels of the process, struggled as a result.
- Most entities struggled to understand and implement guidance on the coverage of COVID-19 tests, particularly initially. Clearly, the frenzied environment associated with the global pandemic and related supply-chain and staffing shortages contributed to this this, but from a lesson-learned perspective, a longer implementation lead time is necessary.
- To make such a system work efficiently, there should be adequate technological support. The rapid COVID-19 test implementation window did not allow for adequate technological development or integration, which is something that will be necessary if there is a future, more pervasive preventive OTC coverage mandate.
- After-the-fact submissions of retail receipts and claims was a very difficult process for both consumers and health plans. Not only are manual claims submissions cumbersome, but a pharmacy receipt is not the same as a typical medical claim in terms of coding and documentation, leading to processing troubles. As a result, many consumers simply did not bother to attempt to obtain ex post facto reimbursement. The federal mail-order system for supplying families with COVID tests through the U.S. Postal Service did work extremely well, so that supports limiting such any future mandate to limited mail-order and online vendors.

8. What other strategies could the Departments implement to increase utilization of OTC preventive products other than, or in addition to, requiring plans and issuers to cover such products without cost-sharing and without a prescription by a healthcare provider? Should the Departments look to any specific strategies implemented by states, localities, plans, issuers or large employers to increase utilization of OTC preventive products? Are there any state laws or regulations currently in place, or expected to be proposed, that could hinder utilization and access to OTC preventive products? If so, what specific requirements in federal regulations could mitigate these barriers to access? Do workplace wellness programs provide access to OTC preventive products? If so, how do such programs manage frequency, method, treatment and

setting to ensure effectiveness, efficiency and access for workers? Does access for workers differ based on their employer's size? If so, how?

NABIP believes public health education efforts would be the best way to increase utilization. We are unaware of any state policy activity that would affect utilization either positively or negatively. Workplace wellness programs do not provide access to OTC preventive products. Worksite coverage programs, such as a pharmacy access for employees at a hospital, may cover OTC preventive products too, but those types of programs are generally rare. Access to OTC preventive products does not vary based on the size of the employer, but generally by the type of employer. Only a very limited set of medical providers or possibly chain drug stores are able and possibly do provide access to OTC preventive care products at the worksite.

C. Health Equity

1. Under current standards and requirements, do certain populations face additional or disproportionately burdensome challenges to accessing OTC preventive products? Do the current standards that require coverage of only prescribed OTC preventive products without cost-sharing pose a substantial burden (for example, excess demand for appointments) on healthcare providers working in, or disproportionately serving, underserved communities? If plans and issuers were required to cover OTC preventive products without cost-sharing and without requiring a prescription by a healthcare provider, how would such a requirement improve access for these populations? For example, is there evidence that coverage of OTC contraceptive medications or devices without a prescription by a healthcare provider would significantly impact access in "contraceptive deserts" (areas with low access to family planning resources)? Could a requirement to cover OTC preventive products without cost-sharing and without a prescription by a healthcare provider potentially increase the retail prices of such products for individuals who purchase them without insurance? If so, what are options for addressing such retail-price increases?

We certainly understand the concern about increased cost burdens for individuals who currently purchase preventive products OTC without a prescription and pay for them directly. However, access to the most commonly utilized contraceptive, condoms, currently does not seem to be affected by its OTC status. In fact, access is likely extensive with OTC contraceptive since public health entities are able to distribute them easily gratis.

Furthermore, it would appear that when preventive care medications are available OTC, like proton pump inhibitors, individuals access them more. When those medications became available OTC decades ago, the incidence rates of related conditions they treat like ulcers requiring inpatient care have only decreased.

The one health equity issue we foresee would be regarding Internet access if coverage were limited to online or mail-order fulfillment; however, that could be addressed by telephone mail-order access.

2. Research suggests that provider bias may play a role in limiting access to certain recommended preventive services, including, for example, contraceptives and other family planning services,

tobacco-cessation pharmacotherapy and medication to reduce the risk of acquiring HIV. Has permitting plans and issuers to require a prescription to obtain coverage for OTC preventive services led to lower utilization rates for certain recommended preventive services among particular populations with respect to different provider types or settings?

NABIP is not a provider organization, so this is not a question we can answer with a great deal of specificity. However, if provider bias is limiting access to certain preventive care services, we believe this is a serious provider-education issue that needs to be addressed through means outside of an OTC non-prescription preventive care first-dollar coverage mandate on health insurance issuers and group plan sponsors.

D. Economic Impacts

1. What are the current annual utilization costs and annual operational costs to plans and issuers related to coverage of OTC preventive products when such products are prescribed by a healthcare provider? Do the costs to plans, issuers and third-party administrators vary for small versus large entities? If so, what are the costs for small entities as compared to large entities?

Since this is not a current common health plan practice, this there is limited cost data available to provide utilization and operational cost estimates. However, research and data do exist on the cost and utilization of preventive care products and medications when directly purchased OTC by individuals. Regarding the impact of the size of the entity on costs, the costs involved would depend on utilization of the services, so costs would not be affected size of employer, but by individual utilization by employees and covered dependents.

2. How would a requirement to cover OTC preventive products without cost-sharing and without a prescription by a healthcare provider affect utilization costs and operational costs to plans, issuers, plan sponsors, third-party administrators, PBMs and retailers? What would be the resulting premium impacts in the short- and long-term? Would utilization of OTC preventive products significantly replace utilization of non-OTC preventive products among participants, beneficiaries and enrollees? Would there be an impact on the cost of non-OTC preventive products? What are the estimated initial and ongoing time and cost burdens on (or savings for) plans, issuers, plan sponsors, third-party administrators, PBMs and retailers if plans and issuers were required to cover OTC preventive products without cost-sharing and without a prescription by a healthcare provider?

On the health side, since this is not a current practice, the available cost data (which is always dependent on utilization) is limited. However, given that the cost of providing preventive care is generally very low relative to typical plan claims expenses, NABIP does not believe that utilization and actual claims costs will be terribly significant.

However, in terms of operations and implementation, we anticipate significant technological and operational costs on the part of both pharmacies and issuers. In addition, given the vast change that such a mandate would impose on purchasing and claims submission at both the retail and reimbursement level, we expect that there will be significant and pervasive operational hiccups. After over 10 years of experience covering preventive services first-dollar with a prescription, claims and

operational errors are still common and costly. Adding a layer of complication would only exacerbate these issues.

3. How would a requirement for plans and issuers to cover OTC preventive products without cost-sharing and without a prescription by a healthcare provider affect price negotiations, pricing decisions, market power, discount or rebate programs, and marketing practices for these products? Would the costs to plans, issuers, third-party administrators, PBMs and providers vary for small versus large entities? If so, what are the impacts for small entities as compared to large entities? What would the net impact of these changes be on prices for and the availability of OTC preventive products?

We do not believe that there would a significant impact on price negotiations, pricing decisions, market power, discount or rebate programs, and marketing practices for these products. However, concerning the cost to issuers, third-party administrators, PBMs and retailers, there would be significant technology, implantation and ongoing operational costs involved, and like all costs, these are eventually passed onto the consumer. From an issuer perspective, how the associated implementation and operational costs associated with a potential OTC non-prescription preventive care coverage mandate, and how these expenses will be considered from a medical loss ratio perspective, is a consideration.

Regarding the net impact of these changes on prices for and the availability of OTC preventive products, again substantial data does not exist to make such projections. However, anecdotally, it does not appear that the price for preventive care medications and items that have always been available and primarily purchased on an OTC basis, such as condoms and proton pump inhibitors, have not been negatively affected because of their OTC status. In fact, it would seem that due to the greater potential for brand competition of OTC products, including store-brand medications, the prices for such items may be lower than the retail price if sold through a pharmacy with a prescription.

4. To what degree would any potential increases in costs or premiums associated with a requirement for plans and issuers to cover OTC preventive products without cost-sharing and without a prescription by a healthcare provider be offset by greater access to OTC preventive products (for example, due to improved health outcomes from greater uptake of recommended preventive products, or fewer office visits as a result of participants, beneficiaries and enrollees no longer requiring an office visit to obtain a prescription for OTC preventive products)?

We do not believe that there are credible sources of information to use to make such predictions since this is not the practice of plans today, so there are no data to examine. However, in general, it takes three to five years of coverage of preventive care services for a health plan to see any return on investment and, in many cases, the coverage of preventive care takes far more years to yield economic or medical fruit.

5. Identify and provide estimates related to the potential societal and economic impacts (for example, benefits, costs and transfers) on individuals and families, as well as on healthcare providers, if OTC preventive products were required to be covered without cost-sharing and without a prescription by a healthcare provider. Would these impacts vary based on region, state, socioeconomic status, race, sex, age, insured status or other factors? For example, would

there be potential reductions in unintended pregnancies or maternal deaths due to participants, beneficiaries and enrollees no longer requiring a prescription for OTC oral contraceptives? As another example, would there be increases in the length of time that children are breastfed if OTC preventive products such as breastfeeding supplies were required to be covered without cost-sharing and without a prescription by a healthcare provider? Would smoking-cessation rates improve with increased access to OTC tobacco-cessation products?

Similarly, since this is not a current practice, there are no significant amount of data to examine to make such predictions. Further, if coverage of OTC preventive products without cost-sharing and without a prescription were required of health plans and issuers, it would take years to establish credible societal and economic impact data.

6. Identify and provide any information regarding the potential impact on health outcomes and quality of life of participants, beneficiaries and enrollees if plans and issuers were required to cover OTC preventive products without cost-sharing and without a prescription by a healthcare provider.

Again, we do not believe that there are credible sources of such information since this is not the practice of plans today, so there are no data to examine. Further, if coverage of OTC preventive products without cost-sharing and without a prescription were required of health plans and issuers, it would take years to establish health outcome and quality-of-life data to review.

7. Identify and provide estimates related to the potential economic impacts (short- and long-term) on healthcare providers, retailers and pharmacists if OTC preventive products were required to be covered without cost-sharing and without a prescription by a healthcare provider. How would the claim processing burden for healthcare providers, retailers and pharmacists change? How would the number of visits to healthcare providers, retailers and pharmacists change?

Since this is not a current practice, and there is no significant economic data to use to make such estimates, we cannot provide specific short- or long-term estimates. However, we can say with certainty that, to implement such a requirement, there would need to be significant changes made to claims-processing procedures and technology. In addition, there would be significant human capital expenses to effectively implement such a change. The technological requirements involved would be both expensive and time consuming to implement, and we anticipate claims-processing issues since these already exist with traditional preventive care coverage.

Regarding preventive care provider visits, we can see how the tenor of such visits could change since, in some cases, people may seek preventive care provider visits simply to obtain the covered medications or devices that might be otherwise available OTC. However, people may access preventive care OTC products more readily since they would not have to go to provider first.

If you have any questions about our comments or if NABIP can be of assistance as you move forward, please do not hesitate to contact me at jgreene@nabip.org or (202) 595-3677.

National Association of Benefits and Insurance Professionals
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Sincerely,

John Greene
Senior Vice President of Government Affairs
National Association of Benefits and Insurance Professionals (NABIP)