

Compensation and Benefits Insights

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Interim Final Rules Regarding Coverage of Preventive Services

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Background

On July 14, 2010, the Departments of Labor, Treasury and Health and Human Services (HHS) jointly released interim final regulations regarding the coverage of preventive health services under the Patient Protection and Affordable Care Act (PPACA) (www.healthcare.gov/center/regulations/prevention/regs.html). For plan years starting on or after September 23, 2010, all group health plans, except grandfathered plans, must cover certain preventive services with no copayments, deductibles or other cost-sharing requirements.

Preventive Services That Must Be Provided Without Cost Sharing

Under PPACA, there are four categories of recommended “preventive” services that non-grandfathered plans must provide without cost sharing:

1. Items or services that have in effect a rating of “A” or “B” in the current recommendations from the U.S. Preventive Services Task Force (USPSTF). Examples include certain screenings for high blood pressure, cholesterol, colorectal cancer, and diabetes, as well as counseling for tobacco use, alcohol misuse, and obesity.
2. Immunizations for routine use in children, adolescents, and adults that are currently recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
3. Preventive care and screenings for respect to infants, children and adolescents provided in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. Preventive care and screenings for women provided in comprehensive guidelines supported by HRSA (and not otherwise addressed by the recommendations and guidelines under #1 or #3 above). However, the recommendations made by the USPSTF in November 2009 that changed the standards with respect to breast cancer screenings are to be disregarded; instead the earlier recommendations from 2002 will be used until additional guidelines are issued. The guidelines are currently being developed by HHS and are expected to be issued by August 1, 2011.

The complete list of recommendations and guidelines that must be covered by plans is located at www.healthcare.gov/center/regulations/prevention/recommendations.html. The regulations provide that if a recommendation or guideline for a preventive service does not specify the frequency, method, treatment or setting for the service, the plan or issuer may use “reasonable medical management techniques” to determine

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any coverage limitations. With respect to new recommendations and guidelines, an interval of not less than one year will be established between when the preventive care requirements are issued and the plan year for which the services addressed in such recommendations or guidelines must take effect. Plans are not required to provide coverage (or waive cost-sharing) once a service ceases to be a recommended preventive service.

Out-of-Network Preventive Health Services

Non-grandfathered plans with provider networks must only cover recommended preventive services delivered by in-network providers. Network plans can either exclude recommended preventive services delivered by out-of-network service providers from coverage and/or impose cost-sharing requirements on such services.

Example: Employees A and B both have a diabetes screening test (a recommended preventive service) performed by their respective primary care physician. A uses an in-network physician, but B uses an out-of-network provider. The plan must cover A's diabetes screening test without cost sharing, but does not have to cover B's screening. If the plan does cover out-of-network diabetes screenings, the plan can impose a cost-sharing requirement on B's procedure.

Cost-Sharing Permitted In Limited Circumstances

In general, non-grandfathered plans cannot impose copayments, deductibles or other cost-sharing requirements on recommended preventive services delivered by an in-network provider. However, cost-sharing is permitted with respect to services that are not specified in the list of recommendations and guidelines (or cease to be so listed). In addition, a plan may impose cost-sharing requirements on a treatment that results from a recommended preventive service (such as a screening), provided that the treatment itself is not a covered recommended preventive service.

The regulations also clarify the cost-sharing requirements when a recommended preventive service is provided in connection with an office visit:

- where a covered preventive treatment is billed separately from an office visit, then the plan may impose cost-sharing requirements with respect to the office visit. (With respect to a plan that uses capitation or a similar payment arrangement that does not bill individually for services, the plan may impose cost-sharing requirements with respect to the office visit where the covered preventive treatment is tracked separately as individual encounter data.)

Example: Employee X covered by a group health plan visits an in-network provider. During the office visit, X is screened for cholesterol abnormalities, which is a recommended preventive service. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test. The plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test, but may impose cost-sharing requirements for the office visit.

As a result of the screening, X is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not a recommended preventive service. The plan may impose cost-sharing requirements for such treatment even though it resulted from the cholesterol screening which was a recommended preventive service.

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- where a recommended preventive service is not billed or tracked separately from an office visit, and the primary purpose for the office visit was to obtain the recommended preventive service, the plan may not impose cost-sharing requirements with respect to the office visit.

Example: Child Y covered by a group health plan visits an in-network pediatrician to receive an annual physical, which is a recommended preventive service. During the office visit, the child receives additional screening tests that are not listed as recommended preventive services. The provider bills for an office visit, but does not separately bill for the additional screening tests. Because the primary purpose of the office visit was the annual physical (a recommended preventive service) and the additional screenings were not billed separately, the plan may not impose cost-sharing requirements on the additional screening tests.

- where a recommended preventive service is not billed or tracked separately from an office visit, but the recommended preventive service was not the primary purpose for the office visit, then the plan may impose cost-sharing requirements with respect to the office visit.

Example: Employee Z covered by a group health plan visits an in-network provider to discuss abdominal pain. During the visit, Z has a blood pressure screening, which is a recommended preventive service. The provider bills the plan for an office visit. Because the primary purpose of the office visit was related to treatment other than blood pressure screening, the plan may impose cost-sharing requirements on the office visit.

Employer Action Required

Implementation of the recommended preventive service rules will require employer action on a number of fronts. Employers should:

1. Work with vendors to identify required changes to in-network preventive coverage and cost sharing requirements, as required changes could impact plan costs and premiums.
2. Determine whether to exclude from coverage or impose cost-sharing requirements on recommended preventive services delivered by out-of-network providers.
3. Work with vendors to determine whether to impose limits on the frequency, method, treatment, or setting based on “reasonable medical management techniques” to the extent not already imposed by the published guidelines.
4. Revise summary plan descriptions and other employee communications to reflect such changes.
5. Review the list of recommended preventive services each year to ensure that any new recommendations are covered for the plan year beginning after the recommendation’s effective date. In addition, an annual review will enable the employer to discontinue coverage or impose cost-sharing with respect to those services that are no longer recommended.

King & Spalding would be pleased to provide you with additional information regarding the new preventive health services rules and assist you with the myriad of health care changes under PPACA.

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