
PPACA Regulations: Preventive Care

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American Benefits Council Call

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Regulations

- Interim Final Regulations (“IFR”) were issued on July 19, 2010
- Comments are requested and due by September 17, 2010
- Applies to individual and group coverage (insured & self-insured)
- Does NOT apply to grandfathered plans

Preventive Care Services

- IFR requires group health plans and issuers to—
 - Cover all “recommended” preventive services, AND
 - Cover such “recommended” preventive services without any cost-sharing

**** Essentially requires first dollar coverage for all
“recommended” preventive services****

Preventive Care Services

- “Recommended” preventive services are defined in the IFR to mean:
 - Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (“Task Force”)
 - Immunizations for “routine” use in children, adolescents, and adults that have “in effect” a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”)
 - Recommendation is considered “in effect” after it has been adopted
 - Immunization is considered “routine” if it appears on the immunization schedules of the CDC

Preventive Care Services

- “Recommended” preventive services are defined in the IFR to mean (cont’d):
 - With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”)
 - With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA

** The complete list of recommendations and guidelines can be found at www.HealthCare.gov/center/regulations/prevention.html **

Office Visits

- IFR provides special cost-sharing rules for “recommended” preventive services offered in connection with an office visit

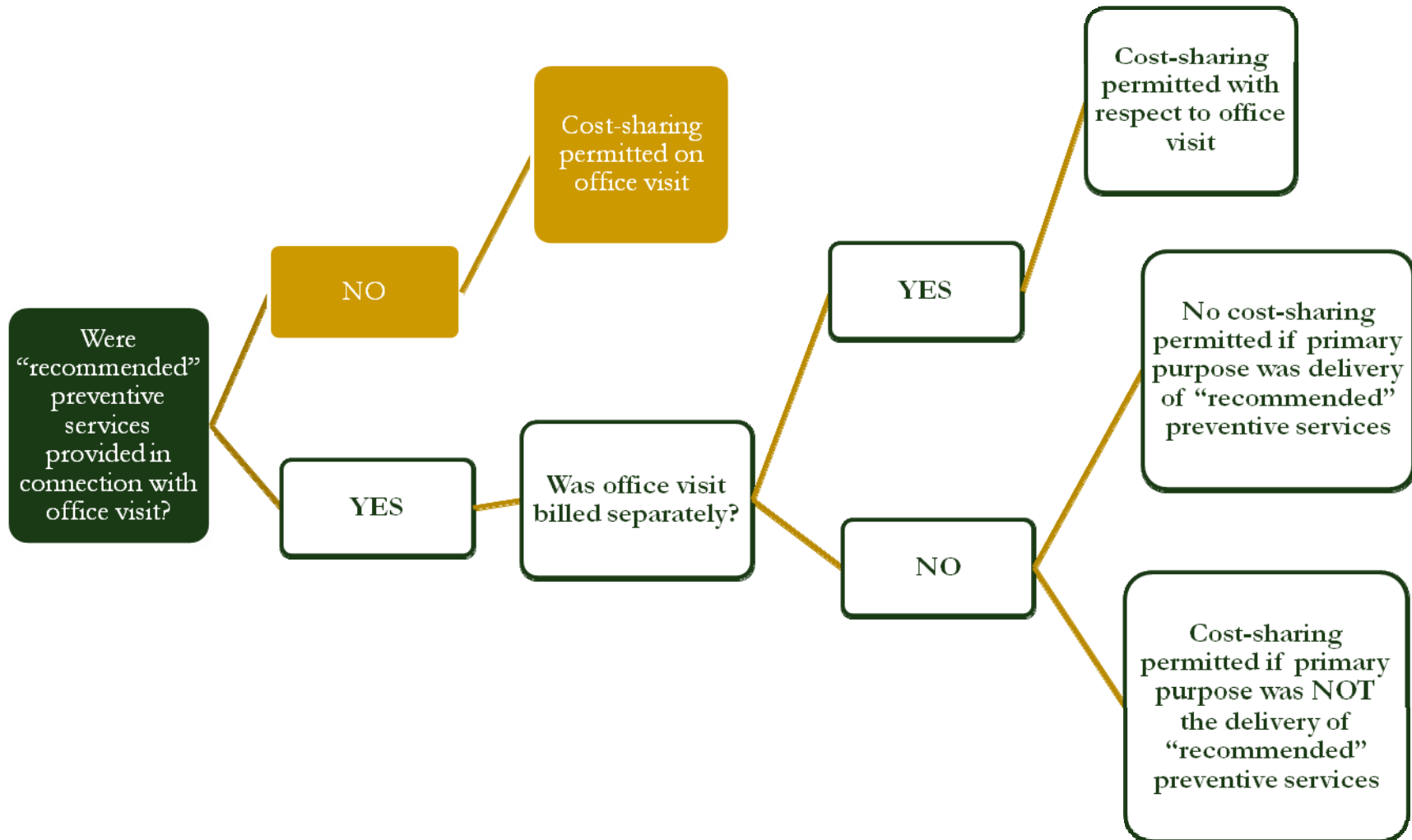
“Several provisions in these interim final regulations involved policy choices. One was whether to allow a plan or issuer to impose cost sharing for an office visit when a recommended preventive service is provided in that visit... The Departments decided that the cost sharing prohibition of these interim final regulations applies to the specific preventive service as recommended by the guidelines.”

Preamble to IFR

Office Visits

- If a “recommended” preventive service is billed separately from an office visit, then cost-sharing MAY be imposed with respect to the office visit only
- If a “recommended” preventive service is NOT billed separately, AND the primary purpose of the office visit is for such preventive services, then cost-sharing may NOT be imposed with respect to the office
- If a “recommended” preventive service is NOT billed separately, AND the primary purpose of the office visit is for a reason OTHER than the delivery of preventive services, then cost-sharing MAY be imposed with respect to the office visit

Office Visits



Office Visits

- Example:

- An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has “in effect” a rating of A or B in the current recommendations of the Task Force. The provider bills the plan separately for an office visit and for the laboratory work of the cholesterol screening test.
 - May impose cost-sharing on office visit because billed separately
 - Cannot impose cost-sharing on screening because constitutes “recommended” preventive services

Office Visits

- Example:
 - An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has “in effect” a rating of A or B in the current recommendations of the Task Force. The provider bills the plan for an office visit and does not separately bill the blood pressure screening.
 - Even though no separate billing is used, plan/issuer may impose cost-sharing because “primary purpose” of office visit was NOT delivery of “recommended” preventive services

Office Visits

- Example:
 - A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the HRSA. During the office visit, the child receives additional items and services that are not “recommended” preventive services. The provider bills the plan for an office visit and does not use separate billing.
 - Notwithstanding the fact that child received services other than “recommended” preventive services, the “primary purpose” of the office visit was for the delivery of “recommended” preventive services. Thus, the plan may NOT impose a cost-sharing requirement with respect to the office visit.

Out-of-Network

- IFR makes clear that plans/issuers may—
 - Provide for no out-of-network coverage of “recommended” preventive services, or
 - Impose cost-sharing on “recommended” preventive services delivered by out-of-network providers

Medical Management

- Although plans/issuers cannot impose cost-sharing on “recommended” preventive services, they are permitted to use “reasonable medical management” techniques to determine the “frequency, method, treatment, or setting” for a “recommended” preventive service, to the extent not specified in the recommendation or guideline

Coverage for “Extra” Preventive Care

- Plan may cover preventive care services that are not on the recommended lists as well (but not required).
- Regulations specify that plan may impose cost-sharing for these services, even if the treatment results from an item or service that was on the list.
 - For example, if first screening is on the list (so required with no cost-sharing), and results of that screening lead to second screening that is not on the list, plan may deny or impose cost-sharing for second screening.

When do new recommendations apply?

- General Rule – When new recommendations are adopted, plan must cover for first plan year beginning on or after one year from adoption.
- Example: For calendar year plan - if new recommendation is adopted 2/1/10, plan must incorporate new recommendation starting 1/1/12.
- For 9/23/10 (this year) – must cover recommendations adopted prior to 9/23/09 – and maybe more if have a later plan year. (Note that some recommendations were adopted 12/31/09, so calendar year plans likely will need to include for 2011.)

When is recommendation considered adopted?

- Task Force – Last day of month on which Task Force publishes or otherwise releases recommendation.
- Advisory Committee – Date adopted by Director of CDC.
- HRSA – Date accepted by the Administrator of HRSA or, if applicable, Secretary of HHS.
- New website will compile list and include date of adoption.

Changes to Recommendations

- If recommendation “falls off the list,” plan no longer required to cover.
- Regulations note that other federal or state requirements may apply related to ceasing coverage or changing cost-sharing.
- For example -
 - If plan changes coverage, this likely would be a plan amendment, so an SMM may need to be provided.
 - State insurance law may still mandate such coverage.

60-Day Advance Notice Rule

- Regulations specifically state that PHSA section 2715(d)(4), “which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective” may apply.
- Question whether agencies intended 60-day advance notice rule to apply now?
- However, section 2715 relates to summary of benefits, which is not required until 24 months from enactment, and 60-day advance notice expressly applies to “changes that are not reflected in the most recently provided summary of benefits.”

Value-Based Plan Designs

- Agencies specifically request comments on value-based plan designs.
- Preamble describes these as provision of information and incentives for consumers that promote access to and use of higher value providers, treatments, and services.
- Preamble says example is imposing cost-sharing for non-network, while covering network (incentive for participants to go in-network).
- Request comments on other types of designs that may be adopted.

Questions?