

## ALERT: HEALTH CARE REFORM BILL

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### MORE HEALTH CARE REFORM REGULATIONS: INTERIM FINAL RULES ON PREVENTIVE CARE

As part of last spring's enactment of the health care reform law, the Departments of Health and Human Services, Labor and the Treasury have been issuing regulations in several phases to implement the law. The fifth phase addresses the Interim Final Rules for Group Health Plans and Health Insurance Issuers relating to Coverage of Preventive Services. (The other phases have been addressed in previously distributed *Willis Alerts*.) The rule generally requires the coverage of certain preventive health services and the elimination of cost-sharing requirements for such services. (**NOTE:** Grandfathered plans can avoid the preventive care service mandate. For information about grandfather status, please see *Willis Human Capital Practice Alert*, Vol. 3, No. 12, "**Regulations on Grandfathered Plans.**")

#### EFFECTIVE DATE

As with the health care reform law's generally phased-in effective date, the regulations become effective with the first plan year after September 23, 2010 (January 1, 2011 for calendar year plans).

#### ITEMS AND SERVICES

Under the new rules, group health plans must provide coverage for certain preventive health services and items and may not impose any cost-sharing requirements (such as a copayment, coinsurance or deductible) with respect to those items or services. These requirements are generally applicable to the following types of recommendations and services:

- 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 (**USPSTF**) with respect to the individual involved
- Immunizations recommended by the **Advisory Committee on Immunization Practices** of the Centers for Disease Control and Prevention for children, adolescents and adults
- Preventive care and screenings for infants, children and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (**HRSA**)
- Evidence informed preventive care and screenings for women as provided for in the comprehensive guidelines supported by the **HRSA** (these guidelines are still under development and expect to be issued no later than August 12, 2011)
- Recommendations of the USPSTF regarding breast cancer screening, mammography and prevention, excluding the recommendation issued in or around November, 2009

Together, these items and services are referred to as “recommended preventive services.” A complete list of these services can be found by [clicking here](#). This link contains the listing of Grade A and Grade B recommendations for preventive services made by the USPSTF as of July 20, 2010, which is the most current listing.

## WHEN RECOMMENDED SERVICES ARE EFFECTIVE

As already noted, the requirement for non-grandfathered group health plans to provide recommended preventive services without cost sharing is effective for plan years beginning on or after September 23, 2010, **or if later**, for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued. Thus, a group health plan with a calendar plan year (the 2011 plan year) that does not maintain grandfather status must provide coverage for recommended preventive services or guidelines issued prior to September 23, 2009.

For the purpose of this one-year timing rule:

- Recommendation or guideline for the USPSTF is considered to be issued on the last day of the month on which the Task Force publishes or otherwise releases the recommendation
- Recommendation or guideline for the Advisory Committee is considered to be issued on the date it is adopted by the Director of the Centers for Disease Control and Prevention
- Recommendations or guidelines in the comprehensive guidelines supported by the HRSA are considered to be issued on the date accepted by the Administrator of the HRSA or adopted by the Secretary of Health and Human Services, if applicable

The federal government’s health care website will be updated on an ongoing basis to keep group health plans informed of when recommendations or guidelines are accepted or adopted.

Now that we know when a recommended preventive service must be provided, what about any service or item that may no longer be required? A group health plan is not required to provide coverage or waive cost-sharing requirements for any item or service that has been eliminated from the recommended preventive services. However, it should be noted that there may be federal or state requirements that must be met before ceasing to provide coverage or changing cost-sharing requirements for such items or services. Currently ERISA provides that any time there is a material reduction in benefits, participants must be notified of the change within 60 days of the adoption of the change. PPACA also requires a 60-day advance notice to an enrollee before any “material modification” can take effect, but the effective date of this provision is unclear.

## COVERAGE AND COST-SHARING RULES

### OFFICE VISITS - SPECIAL RULES

Knowing the rules is one thing. How to apply them in everyday life situations is another. The IFR outlines the rules with respect to cost sharing when required preventive care items or services are provided as part of an office visit.

- If an **item or service is billed separately from an office visit**, then a plan may impose a cost-sharing requirement with respect to the office visit.

**EXAMPLE** An individual receives a recommended preventive service, such as a cholesterol screening test, during a routine office visit. The plan may impose cost-sharing requirements for the office visit because the recommended preventive service is billed as a separate charge.

- If an **item or service is NOT billed separately** from an office visit, and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may NOT impose cost-sharing requirements with respect to the office visit.

**EXAMPLE** A child visits a pediatrician to receive an annual physical exam as part of the comprehensive guidelines supported by the Health Resources and Service Administration. As part of the visit, the child receives a number of services outside of those guidelines. The provider bills the plan for the office visit. In this case, the plan may not impose a cost-sharing requirement with respect to the office visit because the primary purpose for the visit was to deliver

preventive care items and services described as part of the comprehensive guidelines supported by the HRSA.

- If an item or service described is **NOT billed separately** from an office visit and the **primary purpose of the office visit is NOT the delivery of such an item** or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

**EXAMPLE** A participant visits the doctor for stomach pain. As part of the visit, the participant's blood pressure is taken and high blood pressure is discovered. The blood pressure screening is a service that is required to be provided without cost sharing. However, because the primary purpose of the office visit was other than to check the participant's blood pressure, and the blood pressure screening was not billed separately, the plan may impose a cost-sharing requirement on the office visit.

## OUT-OF-NETWORK PROVIDERS

Nothing in the new regulations requires a plan that has a network of providers to provide preventive benefits or services that are delivered by an out-of-network provider. Moreover, nothing precludes a plan that has a network of providers from imposing cost-sharing requirements for preventive items or services that are delivered by an out-of-network provider.

## REASONABLE MEDICAL MANAGEMENT

To the extent that the appropriate guideline for an item or service fails to specify the frequency, method, treatment or setting for the provision of that service, a plan can exercise reasonable medical management to determine any coverage limitations. This use of reasonable medical management provides plans with leeway to adapt the recommendations and guidelines for coverage of specific services and items where cost sharing must be waived.

## SERVICES NOT DESCRIBED

The regulations do not preclude a plan from providing coverage for items and services in addition to those recommended by the USPTSTF or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the HRSA, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines.

## CONCLUSION

As compared to other recently issued health care reform-related regulations, the preventive care regulations appear relatively straightforward. Happily the regulations appear to extend plans some flexibility to require co-pays or other cost sharing for preventive care – as long as the particular treatments are not identified as covered under the appropriate agency requirements or they are provided by an out-of-network provider. Even where non-grandfathered plans are entirely precluded from using cost-sharing tactics, distinguishing between items or services where cost sharing can be used should be easy to identify, and therefore easier to administer. Keep in mind, however, while the Rule does list those recommended preventive services that must be covered without cost sharing for the upcoming plan year, plan sponsors will need to monitor the recommended preventive services list to track future updates for plan years that begin after July 19, 2011. Finally, most commentators do not expect the cost of this mandate to be particularly onerous as measured against most other health care reform mandates.

# KEY CONTACTS

## U.S. HUMAN CAPITAL PRACTICE OFFICE LOCATIONS

### NEW ENGLAND

**Auburn, ME**  
207 783 2211

**Bangor, ME**  
207 942 4671

**Boston, MA**  
617 437 6900

**Burlington, VT**  
802 264 9536

**Hartford, CT**  
860 756 7365

**Manchester, NH**  
603 627 9583

**Portland, ME**  
207 553 2131

**Shelton, CT**  
203 924 2994

### NORTHEAST

**Buffalo, NY**  
716 856 1100

**Cranford, NJ**  
908 931 3005

**Florham Park, NJ**  
973 410 4622

**Morristown, NJ**  
973 829 6374  
973 829 6465

**New York, NY**  
212 915 8802

**Norwalk, CT**  
203 523 0501

**Radnor, PA**  
610 254 7289

**Wilmington, DE**  
302 397 0171

### ATLANTIC

**Baltimore, MD**  
410 584 7528

**Bethesda, MD**  
301 581 4261

**Knoxville, TN**  
865 588 8101

**Memphis, TN**  
901 248 3103

**Nashville, TN**  
615 872 3716

**Norfolk, VA**  
757 628 2303

**Reston, VA**  
703 435 7078

**Richmond, VA**  
804 527 2343

**Rockville, MD**  
301 692 3025

### SOUTHEAST

**Atlanta, GA**  
404 224 5000

**Birmingham, AL**  
205 871 3300

**Charlotte, NC**  
704 344 4856

**Gainesville, FL**  
352 378 2511

**Greenville, SC**  
704 344 4856

**Jacksonville, FL**  
904 355 4600

**Marietta, GA**  
770 425 6700

**Miami, FL**  
305 421 6208

**Mobile, AL**  
251 544 0212

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704 344 4856

**Savannah, GA**  
912 239 9047

**Tallahassee, FL**  
850 385 3636

**Tampa, FL**  
813 490 6808  
813 289 7996

**Vero Beach, FL**  
772 469 2842

### MIDWEST

**Appleton, WI**  
414 259 8837

**Chicago, IL**  
312 288 7700  
312 621 4843  
312 348 7678

**Cleveland, OH**  
216 357 5921

**Columbus, OH**  
614 326 4722

**East Lansing, MI**  
517 349 3226

**Grand Rapids, MI**  
248 735 7249

**Green Bay, WI**  
414 259 8837

**Milwaukee, WI**  
414 203 5248  
414 259 8837

**Minneapolis, MN**  
763 302 7131  
763 302 7209

**Moline, IL**  
309 764 9666

**Pittsburgh, PA**  
412 645 8537  
412 586 3524

**Schaumburg, IL**  
847 517 3469

## **SOUTH CENTRAL**

**Amarillo, TX**  
806 376 4761

**Austin, TX**  
512 651 1660

**Dallas, TX**  
972 715 2194  
972 715 6272

**Denver, CO**  
303 765 1564  
303 773 1373

**Houston, TX**  
713 625 1017  
713 625 1082

**McAllen, TX**  
956 682 9423

**Mills, WY**  
307 266 6568

**New Orleans, LA**  
504 581 6151

**Oklahoma City, OK**  
405 232 0651

**Overland Park, KS**  
913 339 0800

**San Antonio, TX**  
210 979 7470

**Wichita, KS**  
316 263 3211

## **WESTERN**

**Fresno, CA**  
559 256 6212

**Irvine, CA**  
949 885 1200

**Las Vegas, NV**  
602 787 6235  
602 787 6078

**Los Angeles, CA**  
213 607 6300

**Novato, CA**  
415 493 5210

**Phoenix, AZ**  
602 787 6235  
602 787 6078

**Portland, OR**  
503 274 6224

**Rancho/Irvine, CA**  
562 435 2259

**San Diego, CA**  
858 678 2000  
858 678 2132

**San Francisco, CA**  
415 291 1567

**San Jose, CA**  
408 436 7000

**Seattle, WA**  
800 456 1415

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