

Health Care Reform Update

Final Interim Regulations Released on Preventive Care

As reported earlier, effective for the first plan year that begins on or after September 23, 2010, a group health plan and a health insurance carrier must (at a minimum) provide coverage for and must not impose any cost sharing requirements on *preventive items and services*. This requirement does not apply to grandfathered coverage.

On July 14, 2010, final interim regulations were issued which:

- list required preventive items and services;
- make clear that the new rules only apply to in-network benefits; and
- provide that cost-sharing can still apply in certain circumstances where the preventive item or service is provided during an office visit but is not separately accounted for and is not the primary purpose of the visit.

The regulations are available at <http://www.healthcare.gov/center/regulations/prevention/regs.html>.

The following summary provides additional information.

WHAT IS THE REQUIREMENT?

Non-grandfathered group health plans (or the insurance carrier offering group health insurance coverage) must provide coverage for *preventive items and services* and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services.

WHAT ARE THE CATEGORIES OF PREVENTIVE ITEMS 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 with respect to the individual involved (except that recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current).
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC with respect to the individual involved. For this purpose, a recommendation from the Advisory Committee on Immunization Practices of the CDC is considered in effect after it has been adopted by the Director of the CDC, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the CDC.
- 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.
- With respect to women, to the extent not described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Administration (further guidance clarifying what is included in these guidelines is expected in August 2010).

Nothing prevents a plan or carrier from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for a preventive item or service to the extent not specified in the recommendation or guideline.

IS THERE A LIST OF REQUIRED PREVENTIVE ITEMS AND SERVICES?

Yes. For a complete list of these *items and services*, visit:
<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>.

At the end of this article, there is a more detailed list of the required *preventive items or services*, per current recommendations and guidelines.

WHEN MUST A NON-GRANDFATHERED PLAN PROVIDE COVERAGE FOR THE REQUIRED PREVENTIVE ITEMS AND SERVICES?

In general, a non-grandfathered group health plan, or carrier providing non-grandfathered group health plan coverage, must provide coverage for *preventive items and services* for plan years that begin 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, recommendations and guidelines issued prior to September 23, 2009 must be provided for plan years beginning on or after September 23, 2010. For recommendations and guidelines adopted after September 23, 2009, information will be updated on an ongoing basis and will include the date on which the recommendation or guideline was accepted or adopted.

MUST PREVENTIVE SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER BE COVERED WITHOUT COST-SHARING?

There is no requirement that a plan or carrier provide coverage for recommended *preventive items and services* delivered by an out-of-network provider, when the plan provides such coverage through in-network providers. Further, if a plan provides coverage for out-of-network preventive services, a plan or carrier may impose cost-sharing requirements on *preventive items and services* furnished by an out-of-network provider, when such items or services are available in-network.

WHAT IF PREVENTIVE ITEMS AND SERVICES AND OTHER KINDS OF SERVICES ARE PROVIDED IN THE SAME OFFICE VISIT?

If a *preventive item or service* is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or carrier may impose cost-sharing requirements with respect to the office visit.

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 United States Preventive Services Task Force with respect to the individual. 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. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

If a *preventive item or service* is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is not the delivery of a *preventive item or service*, then a plan or carrier may impose cost-sharing requirements with respect to the office visit.

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 United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

The blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver preventive items or services. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

If a *preventive item or service* is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is the delivery of a *preventive item or service*, then a plan or carrier may not impose cost-sharing requirements with respect to the office visit.

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 Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described as a preventive item or service subject to this requirement. The provider bills the plan for an office visit.

The service was not billed as a separate charge and was billed as part of an office visit. The primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

WHAT IF OUR PLAN PROVIDES COVERAGE FOR SERVICES NOT LISTED IN THE GUIDELINES AS PREVENTIVE ITEMS AND SERVICES?

A plan or carrier may provide coverage for items or services that are not required by the law. In this scenario, the plan or issuer may impose cost-sharing requirements on the additional services, so long as such charges are consistent with the terms of the plan and comply with any applicable State insurance law (fully insured plans).

WHAT HAPPENS IF THE RECOMMENDED LIST OR GUIDELINES CHANGE OR CERTAIN PREVENTIVE ITEMS AND SERVICES ARE REMOVED?

A group health plan is not required to provide coverage for any item or service once such item or service is removed as a recommendation or guideline. However, other Federal or State laws (for insured plans) may apply in connection with a plan ceasing to provide coverage for an item or service, including the 2012 requirement that a plan or carrier provide 60 days advanced notice to an enrollee before any material modification will be effective.

As stated earlier, the government intends to update the website containing relevant recommendations and guidelines for *preventive items and services* so that plans can comply with the applicable requirements.

CAN YOU PROVIDE A MORE SPECIFIC LIST OF THE GUIDELINES AND RECOMMENDATIONS FOR PREVENTIVE CARE ITEMS AND SERVICES?

Covered Preventive Services for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with sustained high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults – doses, recommended ages, and recommended populations vary:
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus
 - Influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breast Feeding** interventions to support and promote breast feeding
- **Cervical Cancer** screening for sexually active women

- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Folic Acid** supplements for women who may become pregnant
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Syphilis** screening for all pregnant women or other women at increased risk

Covered Preventive Services for Children

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Cervical Dysplasia** screening for sexually active females
- **Congenital Hypothyroidism** screening for newborns
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight and Body Mass Index** measurements for children
- **Hematocrit or Hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **HIV** screening for adolescents at higher risk
- **Immunization** vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenzae type b
 - Hepatitis A
 - Hepatitis B
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus

- Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling, effective the first plan year after January 31, 2011
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children



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