Preventive Care Rules under the Affordable Care Act

Kilpatrick Stockton LLP
Mark L. Stember
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On July 14, 2010, the Departments of Labor, Treasury and Health and Human Services (the "Departments") issued another round of guidance implementing the Affordable Care Act group health plan provisions. The interim final rules (the "Rules") address the provisions of the Affordable Care Act relating to the preventive care requirements under new Section 2713 of the Public Health Services Act. The preventive care requirements apply only to non-grandfathered health plans as of the first plan year beginning after September 23, 2010 (for calendar year plans, January 1, 2011).

Since the issuance of the grandfathered health plan rules on June 17, 2010, many employers and plan sponsors have become troubled with how the Departments are handling Affordable Care Act implementation. Because the grandfathering rules were clearly designed to push employers and plan sponsors to non-grandfathered status, many employers and plan sponsors have wondered if the Departments would take an even more expansive view of rules applicable to non-grandfathered plans, thereby creating in effect a one-two punch against employer sponsored health plans. However, starting with the emergency room and physician choice rules on June 28, 2010 and now the preventive care rules, it appears that the Departments have taken a more middle-of-the-road approach to Affordable Care Act implementation. Clearly, given the expansive grandfathering rules, the Departments could have taken (and at the time appeared would take) a much more expansive view of the rules applicable to non-grandfathered plans than they have so far.

Preventive Care Rules (PHSA Section 2713)

A non-grandfathered group health plan is required to provide coverage for the following preventive care items and services without any cost sharing requirements (see below for the special cost sharing requirements) –

- ***General Preventive Care.*** Evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- ***Immunizations.*** Immunizations for routine use in children, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- ***Preventive Care for Children.*** With respect to children, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration; and
- ***Preventive Care for Women.*** With respect to women, to the extent not otherwise provided for above, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration.

The guidelines above can be found at http://www.HealthCare.gov/center/regulations/prevention.html The guidelines are extremely specific and comprehensive and go well beyond what the typical employer sponsored group health plan currently considers to be preventive care. For example, the items listed in the United States Preventive Services Task Force include counseling for alcohol misuse, tobacco misuse

and weight management as well as the typical screenings and tests for various diseases and infections. In addition, the preventive care required for children include well-visits through age 21 along with various screenings. The Departments intend to update the site as new recommendations or guidelines are issued. Non-grandfathered group health plans are required to follow newly issued recommendations for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

Cost Sharing Rules for Preventive Care

The Rules impose certain cost sharing requirements on the preventive care items and services listed above.

No Cost Sharing. A plan may not impose any cost sharing requirements on the items and services considered to be preventive care – meaning 100% coverage with no deductibles, co-payments or co-insurance. However, the Rules set forth specific requirements depending on whether the preventive care services are billed separately or combined with an office visit. For example, if the preventive service is billed separately (e.g., a cholesterol screening), then the plan can impose cost-sharing requirements with respect to the related office visit. However, if the preventive service is not billed separately from an office visit (e.g., required weight management counseling) and the primary purpose of the office visit is the delivery of the preventive care service, then the plan may not impose any cost-sharing requirements with respect to that office visit.

Cost-Sharing Rules Only Apply to Network Providers. The Departments could have easily applied the no cost-sharing requirement to both network and out-of-network providers. However, in a middle-of-road approach to the Rules, the Departments applied the preventive care cost-sharing rules to only network providers. This means that coverage for the preventive care items and services listed above is not required if the item or service is provided out-of-network. Further, if a plan did cover some of the preventive care items or services out-of-network, it could subject those items and services to the plan's deductible and apply co-insurance requirements.

Medical Management Allowed. If a recommended preventive care item or service does not specify the frequency, method, treatment or setting for the provision of that service, then a plan can use reasonable medical management techniques to determinate any coverage limitations. For example, with respect to a cholesterol screening, a plan could allow a specific number of screenings per year, plus any additional screenings upon a showing of medical necessity. However, other preventive care services such as counseling for weight management or alcohol/tobacco use will be more difficult. For example, in those situations it is clear that a plan could place a limit on the number of visits that would be paid without cost-sharing (meaning any visits after the limit is reached would be subject to the plan's normal co-insurance or other cost-sharing), but it is unclear whether that limit could be annual, per incident or based on medical necessity in each case. The preamble to the Rules only provides that plans may rely on established techniques and other relevant evidence to determine the frequency of those limits.

Treatment Services Not Affected. The Rules also clarify that a plan may impose cost-sharing requirements for any treatment that is not a recommended preventive item or service, even if the treatment results from a recommended preventive service (e.g., if prescription drugs are needed to control high cholesterol following a cholesterol screening).