



## UNDERSTANDING PREVENTIVE CARE REQUIREMENTS HEALTHCARE REFORM IN AMERICA – Part V

July 2010

ON JULY 14, 2010 THE DEPARTMENTS OF HEALTH AND HUMAN SERVICES, TREASURY AND LABOR RELEASED INTERIM FINAL RULES RELATING TO THE COVERAGE OF PREVENTIVE SERVICES UNDER THE AFFORDABLE CARE ACT (ACA). THIS EDITION OF OUR SERIES – **HEALTHCARE REFORM IN AMERICA** WILL SUMMARIZE WHICH SERVICES MUST BE COVERED WITH NO MEMBER COST SHARING AND CLARIFY HOW A PLAN MAY CHARGE FOR OFFICE VISITS IN CONNECTION WITH THE DELIVERY OF REQUIRED PREVENTIVE SERVICES. THIS MANDATE, WHICH DOES NOT APPLY TO GRANDFATHERED PLANS, BECOMES EFFECTIVE FOR PLAN YEARS THAT BEGIN ON AND AFTER SEPTEMBER 23, 2010.

### WHAT THE LAW SAYS

Under the ACA, self-insured and fully-insured plans must provide certain preventive services with no cost sharing to the member. Certain task force and advisory committee guidelines are referenced to determine the **Recommended Preventive Services (RPS)** that must be provided which includes:

- ◆ 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 (USPSTF) with respect to the individual involved,
- ◆ Immunizations for children, adolescents and adults that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention,
- ◆ With respect to infants, children and adolescents, evidence-informed preventive care and screenings supported by the Health Resources and Services Administration (HRSA),
- ◆ With respect to women, evidence-informed preventive care and screenings provided in comprehensive guidelines supported by HRSA (other than those recommended by the USPSTF), and
- ◆ The current USPSTF recommendations regarding

breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Links to the **Recommended Preventive Services** can be found in the **Appendix** to the *Insights*.

### COST SHARING AND OFFICE VISITS

The interim final rules provide guidance regarding how a plan may determine and charge for an office visit where preventive and other types of services are performed during the visit. The rules state the following:

- ◆ If the Recommended Preventive Service is billed separately\* from the office visit – the plan may impose cost-sharing requirements for the office visit.
- ◆ If the Recommended Preventive Service is is not billed separately\* from the office visit AND the primary purpose of the visit is for the delivery of the preventive service – the plan may not impose cost-sharing requirements for the office visit.
- ◆ If the Recommended Preventive Service is is not billed separately\* from the office visit AND the primary purpose of the visit is NOT for the delivery of the preventive service – the plan may impose a cost-sharing requirement for the office visit.

*\*This includes services that may be tracked as individual encounter data in capitated payment arrangements that do not bill individually for items and services.*

### OUT-OF-NETWORK SERVICES

Recommended Preventive Services performed by an out-of-network provider are not subject to the ACA mandate. Therefore, members can be charged for preventive services when they choose to utilize out-of-network providers.

### RELATED TREATMENTS

The interim rules clarify that a plan may impose cost-sharing requirements for a treatment that is not

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designated as an RPS, even if the treatment is necessary as a result of an RPS screening.

## REASONABLE MEDICAL MANAGEMENT

A plan may use “reasonable medical management” to determine the frequency, method, treatment or appropriate setting for an RPS when there is nothing specified in the recommendations or guidelines.

## CHANGES IN RECOMMENDATIONS AND GUIDELINES

The interim rules state that when the Recommended Preventive Services are changed or modified, the agencies must allow at least a one-year interval between the time the new requirements are issued and the time when plans must comply with new recommendations. Plans would comply on the first plan year that begins one year after the new preventive service guideline is issued.

For example, only those recommendations or guidelines that have been issued prior to September 23, 2009 will have to be covered as a “preventive service with no member cost sharing” at the initial implementation date.

## ESTIMATED BENEFITS AND COST IMPACT

According to the economic impact analysis included with the issuance of the interim final rules, four types of benefits will result from this mandate which include:

- ◆ Individuals will experience improved health,
- ◆ Healthier workers and children will be more productive,
- ◆ Improving access to preventive services can lower plan costs as illness and treatment will be detected earlier, thus avoiding higher-cost services later on, and
- ◆ The cost of providing preventive services will be distributed more equitably among the population.

Furthermore, the Departments estimate that premiums will increase approximately 1.5%, on average, for enrollees in non-grandfathered plans.

## EXAMPLES

**Example 1** – Jane visits an in-network provider and during the visit is screened for high cholesterol (an RPS). The provider bills the plan separately for the office visit and the cholesterol screening lab work. *The plan can require Jane to pay for the office visit (i.e. \$30 copayment) but cannot require cost-sharing for the lab services.*

Jane learns that she has elevated cholesterol and is prescribed a course of treatment that is not on the list of Recommended Preventive Services.

*The plan may impose cost-sharing requirements for Jane’s course of treatment.*

**Example 2** – Joe sees his in-network doctor for abdominal pain that he has been experiencing. During the visit his doctor checks his blood pressure (an RPS). *Joe can be charged for the office visit because the primary purpose of the visit was for his abdominal pain which is not an RPS.*

**Example 3** – David, a 10-year old child, sees his in-network pediatrician for his annual physical in accordance with the HRSA guidelines. During his visit the doctor performs other services that are not an RPS. The pediatrician only bills the plan for an office visit. *The plan may not impose a cost-sharing requirement on David’s parents because the primary purpose of the visit was an annual physical in accordance with the RPS guidelines and the pediatrician did not separately bill for the non-RPS services.*

**Example 4** – Sally sees an out-of-network provider for immunizations that qualify as an RPS. *The plan can impose cost-sharing requirements on Sally for these services as she chose to use an out-of-network provider for these services.*

## ACTION STEPS

Employers and plan sponsors subject to the mandate (i.e. do not retain grandfather status) should work closely with insurance carriers and third party administrators to make sure that the Recommended Preventive Services are covered under the plan and that processes are established to properly administer the cost-sharing requirements. In addition, employers and plan sponsors will need to effectively communicate the cost-sharing requirements during open enrollment. Of course, plan documents and SPDs will also have to be updated.

Plans that retain grandfather status will have to indicate this in open enrollment materials and must be prepared to address how the plan covers preventive services, as this mandate does not apply.

Employers whose next plan year begins BEFORE the ACA

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compliance date (i.e. August 1 and September 1) should consider, as part of the open enrollment communications process, informing employees about the new law and when the various aspects of the legislation will first apply.

## ADDITIONAL INFORMATION

For specific questions concerning information contained in this *Insights*, please contact your Chernoff Diamond consultant.

Information contained in this *Insights* is not intended to render tax or legal advice. Employers should consult with qualified legal and/or tax counsel for guidance in respect of matters of law, tax and related regulation.

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For additional information about our services please contact us at (516) 683-6100 or via e-mail at [mail@chernoffdiamond.com](mailto:mail@chernoffdiamond.com)

# Appendix

## RECOMMENDED PREVENTIVE SERVICES

The Department of Labor's Employee Benefits Security Administration has updated its dedicated Affordable Care Act web page

<http://www.healthcare.gov/center/index.html> with the following information:

### *RECOMMENDED PREVENTIVE SERVICES*

<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>

### *FACT SHEET*

<http://www.healthcare.gov/law/about/provisions/services/background.html>