

July 2010

## Health Care Reform Alert

### New Regulations Define “Preventive Care” and When Cost Sharing is Acceptable

On July 14, 2010, three federal agencies published new regulations defining what is considered “preventive care” for purposes of the health care reform law, the Patient Protection and Affordable Care Act (“PPACA”). PPACA requires that certain group health plans must provide benefits for various preventive care benefits, such as mammograms, colonoscopies, children’s immunizations and certain screenings. PPACA also provides that plans cannot impose cost-sharing requirements (such as copayments, coinsurance or deductibles) for such benefits. The new regulations provide important definitions and clarifications.

#### Four Types of Preventive Care

The regulations provide four types of items or services that will constitute preventive care, as noted in the following chart.

General Type	Examples	Link to Further Information <sup>1</sup>
<u>“A” or “B” Ratings</u> Evidence-based items or services that have in effect a rating of “A” or “B” from the U.S. Preventive Services Task Force.	PKU screening for newborns; osteoporosis screening for most women at age 65; lipid disorder testing for men 35 and older.	A list of the 45 types of “A” or “B” items or services can be found here:  <a href="http://bit.ly/cNenuD">http://bit.ly/cNenuD</a>
<u>Certain Immunizations</u> Immunizations for routine use in children, adolescents and adults if recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	Measles, mumps and rubella for infants aged 12-15 months; certain hepatitis shots if age 7 to 18; human papilloma virus (HPV) for women age 19 to 26.	The list of recommendations is in several documents, all of which can be found here:  <a href="http://bit.ly/8XRKI5">http://bit.ly/8XRKI5</a>

<sup>1</sup> The links in the chart were shortened for formatting purposes related to the chart. The link to the official guidance is here:  
<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>.



<p><u>Evidence-Informed Preventive Care</u> For infants, children and adolescents, evidence-informed preventive care and screenings provided in guidelines supported by the Health Resources and Services Administration.</p>	<p>Autism screening in early childhood; certain height and weight measurements.</p>	<p>The list of recommendations is in two documents, found here:  <a href="http://bit.ly/93nY4E">http://bit.ly/93nY4E</a>  <a href="http://bit.ly/ctYEgf">http://bit.ly/ctYEgf</a></p>
<p><u>Women-Specific Preventive Care</u> With respect to women, certain evidence-informed preventive care and screenings provided in guidelines supported by the Health Resources and Services Administration.</p>	<p>Recommendations currently under development; expected to be completed by August 2011.</p>	<p>Not applicable (still under development).</p>

**Cost-Sharing**

In many cases, an individual may receive a preventive care item or service in conjunction with other services during an office visit. Will the "no cost-sharing" rule also apply to these other, non-preventive services? Perhaps, but it would depend upon whether or not the preventive care item or service is billed (or tracked) separately.

**Separate Billing or Tracking**

If the preventive care item or service is billed or tracked separately, the plan can impose cost-sharing with respect to the other services or items received in the office visit (i.e., the ones that did not constitute preventive care).

For example, suppose a plan participant visits an in-network health care provider. During the visit the individual is screened for cholesterol abnormalities, which is a recommended preventive care service. The provider bills the plan for both the office visit and the separate cholesterol screening test. The plan cannot impose cost-sharing requirements (such as deductibles, copayments or coinsurance) with respect to the cholesterol screening test. However, the plan can impose cost-sharing requirements for the remainder of the office visit.

**If No Separate Tracking, Focus on "Primary Purpose"**

In some situations, the provider will not bill separately for the preventive care items or services versus the other items or services received in the office visit. If so, the plan needs to examine the "primary purpose" of the office visit. If the primary purpose was to obtain the preventive care, then the plan cannot impose a cost-sharing requirement. If the primary purpose was not to obtain the preventive care, then the plan can impose a cost-sharing requirement. It is unclear whether a plan will always know the "primary purpose" of each individual's office visit.



For example, suppose an individual visits a doctor’s office due to abdominal pain. During the visit the person has a blood pressure screening, which is a recommended preventive care service. The provider bills the plan for an office visit, without billing separately for the blood pressure screening. The plan may impose a cost-sharing requirement for the office visit charge because the primary purpose of the visit was the abdominal pain, not the blood pressure screening.

This chart summarizes the different circumstances that can apply.

	<b>Preventive Care Item or Service IS Billed or Tracked Separately From Rest of Office Visit</b>	<b>Preventive Care Item or Service IS NOT Billed or Tracked Separately From Rest of Office Visit; Primary Purpose IS NOT Preventive Care</b>	<b>Preventive Care Item or Service IS NOT Billed or Tracked Separately From Rest of Office Visit; Primary Purpose IS Preventive Care</b>
<b>Can the Plan Impose Cost-Sharing With Respect to Office Visit?</b>	<u>Yes</u> . The plan can impose cost-sharing with respect to the office visit (generally no cost-sharing for in-network preventive care). The “primary purpose” test from the next two boxes is not used.	<u>Yes</u> . The plan can impose cost-sharing with respect to the office visit.	<u>No</u> . The plan cannot impose cost-sharing with respect to the office visit.

**Out-of-Network Providers**

A plan is not required to cover preventive care items or services from an out-of-network provider. If a plan chooses to cover preventive care items or services provided by an out-of-network provider, the plan can impose cost-sharing requirements with respect to those services.

**Flexibility for Other Provisions**

It is possible that the recommendations noted above in the first chart will not provide adequate details relating to the preventive care item or service (e.g., frequency, method, treatment or setting for the item or service). If so, the regulations generally allow a plan to “fill in the gap” and impose such restrictions.

**Follow Up Treatment**

A preventive item or service may lead to follow-up treatment for a condition. The plan generally can impose cost-sharing requirements with respect to the follow-up treatment, even if the plan could not impose cost-sharing requirements for the original preventive item or service.

**Updates and Changes**

Plans must cover new preventive care items or services effective as of the first plan year that begins on or after the date that is one year after the recommendation is issued. For example,



suppose the U.S. Preventive Services Task Force recommends a new preventive care service in March 2011. Suppose a plan sponsor has a calendar year plan. If so, the sponsor's plan would need to cover the new service by January 1, 2013 (one year after the recommendation is issued would be March 2012; the start of the next plan year after March 2012 would be January 1, 2013). This special timing rule is only for future changes (e.g., a new recommendation issued in 2012), not for the current list of preventive care items and services (as noted in the first chart).

U.S. Preventive Services Task Force recommendations relating to breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered "current" and generally do not need to be followed.

### **Grandfathered Plans**

Grandfathered plans do not have to comply with these new regulations.

### **Effective Date**

The new rules are effective for the plan years beginning on or after September 23, 2010 (e.g., January 1, 2011 for a calendar year plan).

### **Cost of Changes**

The regulations estimate that these changes will raise annual premiums for non-grandfathered plans approximately 1.5%. Presumably both fully-insured and self-funded plans will be affected. However, we expect that the effect of this change will vary among clients. Some clients may have plans which already cover all of these preventive care items and services without any cost-sharing. If so, the financial impact for these plans will be minimal or nonexistent. On the other hand, the new rules could represent a more significant cost for other plans that provide less generous preventive care benefits.

### **Additional Resources**

The regulations can be found at: [http://www.ofr.gov/OFRUpload/OFRData/2010-17242\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2010-17242_PI.pdf).

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