eActionAlert

OVERVIEW OF THE PREVENTIVE CARE REGULATIONS

August 6, 2010

*The quality of health care in America is based only **in part** on the quality of our health care system – doctors, hospitals, nurses, etc. The other part of the equation has to do with the number of uninsured, underinsured or poor people who only go to a doctor if they're sick. The inevitable result of this "delayed care" is that illnesses go undetected for long periods of time and, when they finally are discovered, they are more advanced, care is more expensive and mortality rates are higher. The Affordable Care Act will help make wellness and preventive services affordable and accessible to everyone by requiring health plans to cover preventive services and by eliminating cost-sharing (co-pays, co-insurance and deductibles).*

*This **eActionAlert** is an overview of the New Interim Final Regulations (Regulations) released by the Department of Health and Human Services, the Department of Treasury and the Department of Labor. We have posted far more detailed information in the Knowledge Center of our Website. We strongly urge all our readers to review this detailed information. Simply click **here**.*

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NOTE Re: Grandfathered Plans:
Plans are **not** subject to these rules **as long as they** maintain their grandfathered status.

Effective Date:
These Regulations are effective 60 days after Publication in the Federal Register. Because their publication date was July 14, 2010, they become effective September 12, 2010.

Applicability Dates:
These Regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after September 23, 2010.

Impact of State Laws
State laws that impose requirements on health insurance issuers that are stricter than those imposed by the Affordable Care Act will not be superseded by the Affordable Care Act.

Out-of-Network Excluded:
With respect to a plan or health insurance coverage that has a network of providers, these Regulations state that a plan or issuer is not required to provide coverage for recommended preventive services delivered by an out-of-network provider.

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Such a plan or issuer may also impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider.

Special *Delayed* Effective Date for Child Obesity Screening:

The recommendation on screening and counseling for obesity in children went into effect on January 31, 2010. Recommendations become a **rule** on the **later** of:

1. The first day of the first plan year beginning on or after September 23, 2010. In the case of a calendar-year plan, this will be January 1, 2011, or,

2. The first day of the first plan year beginning one year after the recommendation went into effect from the particular agency or task-force. In the case of a calendar-year plan, this will be January 1, 2012.

Frequency of Preventive Care:

These Regulations provide that if a recommendation or guideline for a preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical-management techniques to determine any coverage limitations. The use of reasonable medical-management techniques allows plans and issuers to adapt these recommendations and guidelines to coverage of specific items and services where cost-sharing must be waived. Thus, a plan or issuer may rely on established techniques and the relevant evidence to determine the frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.

Cost-Sharing for Office Visits:

The regulations clarify the cost-sharing requirements when a recommended preventive service is provided during an office visit.

First, if a recommended preventive service is billed or tracked separately from an office visit, a plan may impose cost-sharing requirements with respect to the office visit.

Second, if a recommended preventive service is not billed or tracked separately and the primary purpose of the office visit is the delivery of such preventive service, then a plan or issuer may **not** impose cost-sharing requirements with respect to the office visit.

Finally, if a recommended preventive service is not billed or tracked separately and the primary purpose of the office visit **was not** the delivery of such preventive service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. Cost-sharing is also permitted for preventive care services that are in addition to those required by law.
(The reference to service tracking was included to provide guidance for plans and issuers that use capitation or similar payment arrangements that do not bill individually for items and paid services.)

What the Regulations Basically Do:

They take several agency and task force recommendations and, by the stroke of a pen and the miracle of "incorporation by reference", give them the force of law.

What Happens if a Recommendation is Eliminated?

These interim final regulations make clear that a plan or issuer is not required to provide coverage or waive cost-sharing requirements for any item or service that has ceased to be a recommended preventive service.

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Other requirements of Federal or State law may apply in connection with ceasing to provide coverage or changing cost-sharing requirements for any such item or service.

What Happens if a Recommendation is Added?
Plans will have one year to implement at 100%.

What This Means for You:
Depending on your age and health plan type, you and members of your family will have access to a whole host of preventive and wellness services without deductibles, co-insurance or co-payments. These tests, screenings and assessments will enable families to identify health problems early-on, and in some cases, before there are any symptoms.
(A complete list of these services is included in the full-details article posted on our Website.)

What Action Should Be Taken Right Now?
These proposed Regulations are now in a 60-day comment period closing September 12, 2010. Because the final regulations could differ significantly, employers should stay in close contact with their benefits consulting firm so they will be prepared to take action as needed when the Regulations are finalized.

As we have in the past, we will continue to monitor Health Care Reform developments and report them to you as soon as practicable.

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