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Preventive Care Guidance for Non-Grandfathered Health Plans Released

The agencies responsible for enforcing the health care reform law have released interim final regulations detailing the preventive care coverage requirements applicable to non-grandfathered health plans. Like other recent guidance, these regulations answer many questions, but raise others. As plan sponsors consider plan changes that could cause loss of grandfathered status, these rules help plans quantify the potential financial and administrative impact of its loss.

Background

The Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010, was enacted on March 23, 2010. The new law will have a far-reaching impact on most health plans. (See our April 21, 2010 *For Your Information*.) There are two major categories of health benefit plans under the law – grandfathered and non-grandfathered. Plans in existence on March 23, 2010 will be grandfathered if certain requirements are met. New plans, and those that fail to maintain grandfathered status, are subject to a larger set of requirements than grandfathered plans. These requirements include the following that are effective for plan years beginning on and after September 23, 2010 –

- coverage of preventive care at 100%
- patient protections regarding choice of providers and coverage of emergency care (see our July 2, 2010 *For Your Information*)
- coverage of children to age 26 even if eligible for other employer-sponsored coverage (see our May 13, 2010 *For Your Information*)
- internal appeals and external review process
- nondiscrimination rules applicable to insured plans
- various reporting requirements.

As they prepare for the coming plan year, many plan sponsors have considered changes that could cause loss of grandfathered status. Understanding the implications of the rules applicable to non-grandfathered plans will assist in the decision-making process. (See our June 23, 2010 *For Your Information*.)

The agencies have now released interim final regulations describing the preventive care rules applicable to non-grandfathered plans. To assist plans in tracking these standards, the government has also set up a website that contains a plethora of information and will continue to provide information on all standards as they are updated.

Interim Final Regulations

Standards for Preventive Care

In describing the types of preventive care that must be covered by non-grandfathered plans, Congress chose to reference guidelines developed by several different federal agencies. These agencies typically have responsibilities involving public health promotion, and have not traditionally been in the business of setting standards for insurance policies. The agencies involved are –

- United States Preventive Services Task Force
- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Health Resources Services Administration.

Each agency has a different process for developing and finalizing its standards, and standards can change at various times during the year. A special effective date rule (described below) will assist plan sponsors in planning for future years.

The standards include many items and services of a nature typically provided by employee benefit plans, such as a wide range of vaccines and screenings for cancer and other diseases. The standards also include physician counseling on a number of health issues, which often takes place in the context of physician office visits, nutrition services or other care already covered by most benefit plans. There are, however, several items cited by the new regulations that are not typically covered by employer-sponsored benefit plans, including –

- aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage
- aspirin for women age 55 to 79 years when the potential benefit due to a reduction in ischemic strokes outweighs the potential harm due to an increase in gastrointestinal hemorrhage
- fluoride supplements for preschool children over age 6 months whose primary water source is deficient in fluoride
- daily supplements of folic acid for all women planning or capable of pregnancy.

BUCK COMMENT. *It is hoped that more guidance will be forthcoming as to whether non-grandfathered plans will be required to provide reimbursement for these treatments. It would be somewhat burdensome to adjudicate these types of claims, and certain items might not be able to be covered by an employee benefit plan on a tax-favored basis.*

The standards generally specify the frequency, method, treatment or setting of a preventive service. The regulations provide that where they do not, a plan may make its own determination using "reasonable medical management techniques."

BUCK COMMENT. *For example, the standards currently do not prescribe the frequency of colonoscopies for adults age 50 through age 75. Therefore, a plan may determine how frequently it will provide first dollar coverage of colonoscopies based on "reasonable medical management techniques."*

Plan Payments

Under the regulations, plans must cover the mandated preventive items without imposing any cost-sharing requirements. In addition to eliminating any copayments or coinsurance, non-grandfathered plans will need to eliminate other cost-sharing features on these services, such as the application of a deductible or the imposition of an annual dollar limit on preventive services.

For preventive services provided in a physician office setting, there can be no cost-sharing if the primary purpose of the visit is the preventive care. However, an office visit copayment (or other applicable cost-sharing) can be imposed in situations where the preventive services are not billed separately and the primary purpose of the office visit is for other than the preventive care.

Importantly, the regulations allow network plans to limit preventive care to in-network providers. Plans may choose to pay only for in-network preventive care, or to cover out-of-network preventive care with cost-sharing.

BUCK COMMENT. *This is welcome news for plan sponsors, as most PPO plans typically do not cover preventive care delivered by non-network providers or subject preventive care to cost-sharing.*

Compliance with Changing Standards

The various preventive standards released by the agencies are not static, and historically they have been updated with some frequency. As new standards are released, it will be important for non-grandfathered plans to adjust accordingly. Fortunately, the regulations provide a mechanism for plans to stay in compliance with these moving targets. For each plan year, the applicable standards will be those in effect at least one year prior to the beginning of the plan year. For calendar year plans, for example, this will mean that for the plan year beginning January 1, 2011, compliance with standards issued prior to January 1, 2010 will be required.

In addition, if a particular standard is revoked by the agencies, plans will not be required to continue covering the affected service or item at 100%. However, they will be required to provide enrollees at least 60 days advance notice before changing how the service is treated.

Effective Date

Non-grandfathered plans will need to be in compliance with the preventive care rules as of the first day of the first plan year beginning on or after September 23, 2010. Grandfathered plans that later lose that status will need to comply on the first day of the plan year in which they are no longer considered grandfathered.

Conclusion

Buck's consultants would be pleased to discuss these latest regulations and the standards for preventive care with you and how they may affect your health plans.