Health Care Reform Advisory: IRS, DOL, and HHS Issue Guidance on Preventive Care under Health Care Reform

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By Alden J. Bianchi

The insurance market reforms enacted as a part of The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Act") establish a series of new requirements that will apply, in phases, to individual and group health insurance contracts and employer-sponsored group health plans. Included is a curb on cost-sharing for "evidenced-based preventive services." On July 14, 2010, the Internal Revenue Service, the U.S. Department of Labor, and the U.S. Department of Health and Human Services issued an interim final regulation (the "Regulation") interpreting the preventive services provisions of the Act. This alert summarizes the key features of the Regulation.

The Regulation is the latest in series of rules promulgated under the Act. Previous installments include:

- A Request for Information relating to medical loss ratios (April 14, 2010)
- Rules governing dependent coverage of children to age 26 (May 13, 2010)
- Grandfathered health plans (June 17, 2010)
- Preexisting condition exclusions, lifetime and annual dollar limits, restrictions on rescissions, and certain patient protections (June 28, 2010)

Background

The Act's bar on cost-sharing for evidence-based preventive care service addresses Congress' concern that there is current underutilization of such services. According to the preamble to the Regulation, underutilization stems from three factors. First, owing to turnover, insurance carriers have little incentive to cover preventive services, since they will not benefit if an individual is no longer be enrolled. Second, many preventive services generate benefits that do not accrue immediately, making individuals less willing to avail themselves of the services particularly in the face of direct, immediate costs. And third, some of the benefits of preventive services accrue to society as a whole, and thus do not get factored in to an individual's decision-making over whether to obtain such services.

The preamble to the Regulation spends considerable time establishing the salutary effects of proper preventive care. Citing data from government commissions and other sources, the regulators build a compelling case for the benefits of overcoming financial and behavioral impediments to proper utilization of evidence-based preventive medicine. The benefits include greater worker productivity and reduced absenteeism rates.

The Act's provisions relating to preventive care services take effect for plan and policy years commencing after March 23, 2010. For calendar year arrangements, this means January 1, 2011.

The Regulation

Under the Regulation, group health plans and health insurance policies issued by state licensed insurance carriers may not impose cost-sharing requirements with respect to the following items (which the Regulation refers to collectively as "recommended preventive services"):[1]

- Evidence-based items or services that have in effect a rating of A or B in the *current* recommendations of the United States Preventive Services Task Force with respect to the individual involved. (A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the Centers for Disease Control and Prevention.)
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. (A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the Centers for Disease Control and Prevention.)
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the Health Resources and Services Administration

The Regulation clarifies that group health plans are not required to provide coverage for recommended preventive services furnished by out-of-network providers.

The Regulation establishes rules governing the imposition of cost-sharing where a recommended preventive service is provided during an office visit. If a recommended preventive service is billed separately from an office visit, then a plan or carrier may impose cost-sharing requirements with respect to the office visit. But if a recommended preventive service is not billed separately from the office visit, the Regulation requires a determination of the "primary purpose" of the visit. If the primary purpose is preventive in nature, the plan or carrier may not impose a cost-sharing requirement. (The Regulation includes a parallel set of rules for capitated arrangements that track individual encounter data.) A plan or contract that covers preventive services that are in addition to recommended preventive services is free to impose cost-sharing requirements for the additional services.

The Regulation also sets out rules for determining when newly identified recommended preventive services must first be taken into account. Generally, plans and carriers have a grace period of up to a full plan year to eliminate cost-sharing with respect to identified items. Thus, recommended preventive services must be covered for plan years beginning on or after the later of September 23, 2010 or one year following the date the recommendation is issued.

Impact of Grandfather Plan Status

"Grandfathered" group health plans and health insurance polices and contracts are exempt from the Act's requirements relating to first-dollar coverage of preventive care. (For information on grandfathered plans, please see our June 16, 2010 Alert.) The rules governing first-dollar coverage or preventive care are generally regarded as vastly expanding coverage, even in the case of very generous plans. As a result, plans that are able to secure and retain grandfather status will enjoy a significant cost advantage over non-grandfathered arrangements.

Conclusion

This is the latest in what amounts to a torrent of new guidance that plans and carriers will need to first absorb and then implement. The Regulations were issued in "interim final" form, which gives them the immediate force of law. As a result, they can be relied upon as plan sponsors and carriers go about amending plans to comply with preventive care rules.

Endnotes

[1] A complete list of recommendations and guidelines covered by the Regulations is available at: http://www.HealthCare.gov/center/regulations/prevention.html.

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Alden J. Bianchi
Chair, Employee Benefits and Executive Compensation
(617) 348-3057
AJBianchi@mintz.com

Tom Koutsoumpas
Senior Vice President of ML Strategies/U.S.

(202) 434-7477
TKoutsoumpas@mintz.com

Karen S. Lovitch
Practice Leader, Health Law Practice
(202) 434-7324
KSLovitch@mintz.com

Jeremy Rabinovitz
Senior Executive Vice President of Government Relations, ML Strategies
(202) 434-7443
JRabinovitz@mlstrategies.com

Stephen M. Weiner
Chair, Health Law Practice
(617) 348-1757
SWeiner@mintz.com