SEYFARTH SHAW ATTORNEYS LLP

Issue 10

Required First Dollar Coverage for Preventive Services

This is the tenth issue in our series of alerts for employers on selected topics in health care reform. (Click here to access our general summary of health care reform and other issues in this series). This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

The Patient Protection and Affordable Care Act (PPACA), as modified by the Health Care and Education Reconciliation Act of 2010 (HCERA) (collectively the "Act"), requires all group health plans to comply with certain mandates, although some of these mandates only apply to non-grandfathered plans (see our earlier alert on grandfathering). This issue focuses on the Act's requirement that all non-grandfathered plans provide first dollar coverage for preventive services. Recently released interim final rules clarify the meaning of "preventive services" and provide other information important to sponsors of non-grandfathered plans.

[ ] Applies to grandfathered plans

[√] Applies to new health plans and plans that lose grandfathered status

First Dollar Coverage for In-Network Preventive Services

The interim final rules require non-grandfathered group health plans to provide first dollar coverage for certain in-network preventive services. This means plans must cover and pay all costs of those in-network preventive services with no additional cost to the participant (i.e., no cost-sharing, copayment or coinsurance). Specifically, the rules require coverage for four categories of preventive services:

- Services rated "A" or "B" by the U.S. Preventive Services Task Force (USPSTF)[1]
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings for children as recommended by the Health Resources and Services Administration
- Preventive care and screenings for women as recommended by the Health Resources and Services Administration

[1] The Act specifies that the USPSTF's recommendation on breast cancer screening and mammography should not be considered current. Instead, the USPSTF's 2002 recommendation on these services applies. Healthcare.gov includes a complete list of recommended preventive services under the Act, including the 2002 recommendation on breast cancer screening and mammography.

The recommendations of these groups cover pages of preventive services, including services such as mammograms, colonoscopies, cancer screenings, blood pressure tests, counseling to quit smoking, health checkups, and immunizations for children. Click here for a complete list of services.

Coverage for Preventive Services vs. Coverage for Office Visits

The interim final rules require first dollar coverage for preventive services, but they do not necessarily prohibit cost-sharing for office visits relating to those services. Nonetheless, first dollar coverage for office visits may be required if the primary purpose of the visit is to receive a covered preventive service. The following table illustrates cost-sharing limitations for office visits:

Description	Cost-Sharing for Office Visit Permitted?
Office visit and covered preventive service *billed separately*	Yes
Office visit and preventive service *not billed separately* & Primary purpose of office visit is delivery of covered preventive service	No
Office visit and preventive service *not billed separately* & Primary purpose of office visit *is not* delivery of covered preventive service	Yes

Cost-Sharing is Permitted for Preventive Services in Some Circumstances

The interim final rules specify that in some instances, non-grandfathered plans may still impose cost-sharing for preventive services. These include:

Preventive Services Not Recommended. The interim final rules make clear that plans may still impose cost-sharing for those preventive services not covered in the recommendations listed above. Also, if the USPSTF or one of the agencies listed above drops its recommendation for a specific preventive service at some point in the future, plans will no longer be required to provide first dollar coverage for that service.

Out-of-Network Preventive Services. Plans may impose cost-sharing for (or choose not to cover) preventive services included in the recommendations if those services are provided out-of-network.

Frequency, Method, Treatment or Setting Limitations. Many of the covered preventive services include a recommendation as to frequency, method, treatment or setting for the provision of that service. For instance, the USPSTF recommends a one-time screening for abdominal aortic aneurysms for men of certain ages who have ever smoked. A plan may limit coverage of preventive services to correspond to these limitations. To the extent the recommendation does not include such a recommendation relating to frequency, method, treatment, or setting, however, the interim final rules allow the plan to use "reasonable medical management techniques" to determine coverage limitations (i.e., a limit on the frequency of participant colonoscopies).

Treatment for Conditions Diagnosed through Preventive Services. Finally, plans may impose cost-sharing for the treatment of conditions diagnosed as a result of one of the recommended preventive services. For instance, if a participant's colonoscopy reveals that participant has colon cancer, the plan may require cost-sharing for cancer treatments (although not for the initial colonoscopy).

Is the List of Preventive Services Subject to Change?

The USPSTF and other agency recommendations are always subject to change. Acknowledging this, the interim final rules only require health plans to cover those preventive services that are recommended at least one year prior to the start of the plan year. For instance, in 2011, calendar year plans are only required to cover those preventive service recommendations in place as of December 31, 2009.

Healthcare.gov includes a "date in effect" column next to each preventive service recommendation so plan sponsors will only need to visit the site once per year to determine which services must be covered with no cost-sharing.

Employer Action Plan

- Determine whether your plan is grandfathered.
- If you maintain a new or non-grandfathered plan, review the list of preventive service recommendations to ensure your plan covers these services with no cost-sharing.
- Determine whether to impose cost-sharing on out-of-network services.
- Determine whether to impose limits on frequency, method, treatment or setting using reasonable medical management techniques, to the extent the guidelines do not already impose such limits.

For further details, or if you have any questions regarding the preventive service requirements, contact your Seyfarth Shaw LLP attorney or any Employee Benefit attorney listed on the website at www.seyfarth.com/employeebenefits, or send your questions to HealthReform@seyfarth.com.