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LEGAL ALERT

July 21, 2010

Agencies Issue Rules Implementing Preventive Care Requirements

Background

On July 19, 2010 the tri-agency task force[1] charged with drafting regulations under the Patient Protection and Affordable Care Act (PPACA) published interim final regulations implementing PPACA's preventive care coverage and cost-sharing requirements for group and individual health plans. The new preventive care requirements do not apply to grandfathered group or individual health plans. However, grandfathered plans that choose to implement the new preventive care requirements may do so without jeopardizing the plan's grandfathered status.

The rules clarify the application of PPACA's first-dollar preventive care coverage requirements, which are effective as of the first day of the first plan year beginning on or after September 23, 2010 (Effective Date). Specifically, the rules: (1) specify the four categories of preventive care services and items that a plan is required to cover – all of which must be covered without cost-sharing; (2) explain the timing for adopting future changes to the plan's preventive care coverage based on changes to the applicable regulations or guidelines within the four categories; and (3) explain when the plan may, and may not, require cost-sharing for an office visit associated with a preventive care visit.

Categories of Recommended Preventive Services

The new rules list four categories of preventive care items and services that must be covered without cost-sharing under a non-grandfathered group or individual health plan (recommended preventive services):

(1) Items and services rated A or B by the U.S. Preventive Services Task Force;

(2) Immunization recommendations that have been issued by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) to the extent that the recommendations have been adopted by the Director of the CDC and listed on the CDC's Immunization Schedules;

(3) Childhood preventive care screenings provided for by the Health Resources and Services Administration (HRSA); and

(4) Women's preventive care and screenings provided under HRSA Guidelines.[2]

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[1] The tri-agency task force consists of the Internal Revenue Service, U.S. Department of the Treasury; the Employee Benefits Security Administration of the Department of Labor; and the Department of Health and Human Services' Office of Consumer Information and Oversight.

[2] In accordance with PPACA, until new guidelines are issued, the 2002 recommendations regarding breast cancer screening, mammography, and prevention will be considered current, rather than the 2009 recommendations.

Plans may provide coverage for items and services in addition to those described above with or without cost-sharing. In addition, to the extent that the relevant guideline does not specify the recommended frequency for a preventive care service, the method for delivering the service, or some other specific aspect of providing the service, plans may use "established techniques and relevant evidence" to determine those aspects of delivering the service.

A complete list of the current recommended preventive services can be found at the Administration's PPACA implementation website. The website includes all recommendations and guidelines under the four categories that are in effect as of July 13, 2010, and it will be regularly updated to reflect changes to recommended items or services.

Future Changes to Recommended Services

Consistent with PPACA, the rules apply a one-year interval between the date when new recommendations or guidelines are issued and the plan or policy year for which coverage of the recommended service must be in effect. Thus, plans must cover items and services recommended as of September 22, 2009 beginning on the first day of the first plan year following the Effective Date. Plans may use the following schedule as a general guideline for covering recommended preventive services:

For Recommendations Guidelines Issued:	**The Recommended Item or Service Must Be Covered Beginning:**
Prior to 9/23/09	On the first day of the first plan year beginning on or after 9/23/10 (January 1, 2011 for calendar year plans)
On or after 9/23/09	First day of the first plan year following the one-year anniversary of the date that the recommendation or guideline was issued

While the rule will require plan sponsors to check the Administration's PPACA implementation website annually for an updated list of recommended preventive services, the one-year interval between issuance and implementation eliminates the need for mid-year changes to covered preventive care services. Thus, if a new recommendation for a preventive care service were issued on November 30, 2010, a non-grandfathered calendar year group health plan would not be required to cover the service until January 1, 2012.

While a plan may eliminate coverage or institute cost-sharing for a previously recommended item or service that is subsequently eliminated pursuant to applicable guidelines, the preamble to the rule suggests that such a change may be a "material modification" under PPACA's advance notice requirements for group health plans,[3] and the plan may be required to provide participants with 60 days' advance notice prior to the change.

[3] The advance notice requirement is made part of the Public Health Services Act (PHSA) (section 2715(c)(4), as added by PPACA).

Cost-sharing Restrictions

Generally, PPACA provides that a plan may not impose any cost-sharing requirements in connection with a recommended preventive service. However, the new rule clarifies that plans may require cost-sharing (such as co-payments or co-insurance) for office visits during which a recommended preventive service is provided if the service: (1) is clearly billed or tracked separately, or (2) is not the primary purpose of the visit.

In-Network Services

If a plan seeks to implement cost-sharing in connection with an in-network office visit, the plan must first determine if any service provided in connection with the visit was a recommended preventive service. If a recommended preventive service is provided in connection with the visit, the plan must then determine if the preventive service is billed separately or tracked as a separate encounter. If the service is billed or tracked separately, the plan may require cost-sharing for the office visit (but not the recommended preventive service). If the service is not billed or tracked separately, the plan must then examine whether the primary purpose of the visit is the delivery of the recommended preventive service. It is unclear whether the plan makes this determination based on information received from the provider, or if the determination is made by the provider independently. If the primary purpose of the visit was the delivery of the recommended preventive service, the plan may not impose cost-sharing for the office visit. If not, the plan may require cost-sharing for the office visit, but not the preventive care item or service. Also, if a patient receives treatment as a result of a preventive screening, examples included in the rules indicate that the treatment can be subject to cost-sharing requirements if the treatment is not itself a recommended preventive service, and, presumably, only if it is billed or tracked separately from any recommended preventive service provided during the same visit.

Out-of-Network Services

In an effort to promote "value-based insurance designs," the rules provide that plans may require cost-sharing for recommended preventive services delivered by out-of-network providers while eliminating cost-sharing requirements for in-network providers; however, plans may not, presumably, refuse to cover recommended preventive services provided by out-of-network providers. The rules state that the tri-agency task force is seeking comments on similar value-based designs that incentivize the use of higher-value providers for preventive care services.

See the attached decision tree outlining the rules for when cost-sharing may still be imposed under a non-grandfathered plan.

Conclusion

The new preventive coverage and cost-sharing restrictions will require non-grandfathered plans to reconsider current provider billing practices. If the plan requires a cost-sharing payment for an office visit at the point of service, each patient encounter will need to be carefully coded during each visit. In many cases, plans and issuers that continue cost-sharing in connection with office visits will need more detailed provider billing summaries in order to demonstrate compliance with the rules. In addition, plans may need to examine the potential impact of any changes in the level of detail on bills on the patient privacy protections afforded by both the Health Insurance Portability and Accountability Act (HIPAA) and the Genetic Information Nondiscrimination Act (GINA).

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If you have any questions about this Legal Alert, please feel free to contact the attorneys listed below or the Sutherland attorney with whom you regularly work.

Daniel M. Buchner	202.383.0869	daniel.buchner@sutherland.com
Adam B. Cohen	202.383.0167	adam.cohen@sutherland.com
Jamey A. Medlin	404.853.8198	jamey.medlin@sutherland.com
Alice Murtos	404.853.8410	alice.murtos@sutherland.com
Joanna G. Myers	202.383.0237	joanna.myers@sutherland.com
Robert J. Neis	404.853.8270	robert.neis@sutherland.com
Vanessa A. Scott	202.383.0215	vanessa.scott@sutherland.com
W. Mark Smith	202.383.0221	mark.smith@sutherland.com
William J. Walderman	202.383.0243	william.walderman@sutherland.com
Carol A. Weiser	202.383.0728	carol.weiser@sutherland.com

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Decision Chart for Imposing Cost-Sharing Requirements for Office Visits Associated with Preventive Care Services (based on PPACA Interim Final Rule dated July 19, 2010)