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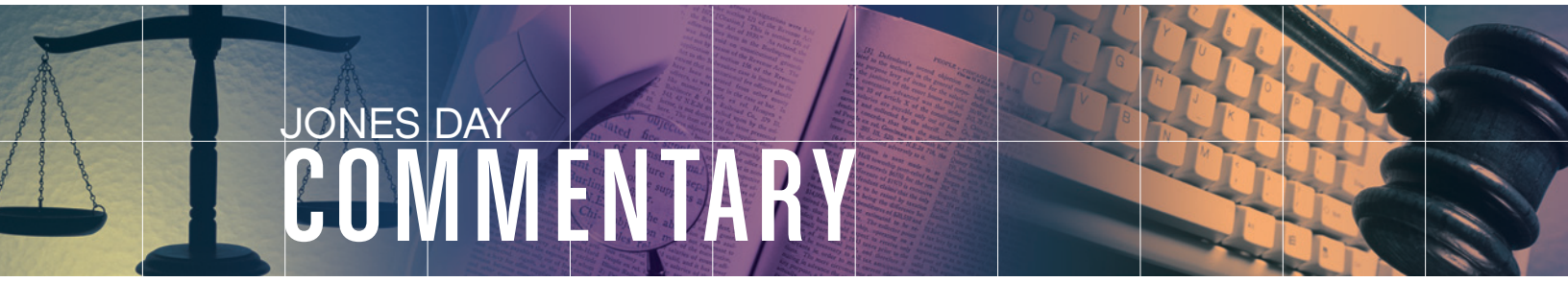

AN OUNCE OF PREVENTION—NOT JUST A GOOD IDEA, NOW IT'S THE LAW: HEALTH CARE REFORM REQUIRES EMPLOYER-SPONSORED GROUP HEALTH PLANS TO PROVIDE PREVENTIVE SERVICES WITH NO COST-SHARING

The Patient Protection and Affordable Care Act, as amended ("PPACA"), requires employer-sponsored group health plans[1] to provide coverage for certain preventive services and to do so without any cost-sharing.

On July 14, 2010, the Departments of Treasury, Labor, and Health and Human Services ("Departments") issued final regulations implementing the preventive services mandate under PPACA. The regulations provide that the mandatory coverage rules apply only to in-network providers and clarify how the cost-sharing prohibition applies with respect to preventive services provided in connection with office visits. The new rules take effect for plan years beginning on or after September 23, 2010 and do *not* apply to grandfathered plans.[2]

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1 The PPACA changes also apply to health insurance policies issued by insurance companies. The discussion in this *Commentary* about group health plans applies equally to health insurance policies issued to such plans.

2 Generally, "grandfathered plans" are plans in existence on March 23, 2010 that have continuously covered at least one person since that time and have not made significant changes in cost or coverage. For a more detailed discussion about grandfathered plans, see the Jones Day *Commentary* entitled "The More Things Change, the More They Stay the Same: Is It Worth Maintaining Grandfathered Status Under the New Health Care Law?" (June 2010), published on the Jones Day web site.

WHAT PREVENTIVE SERVICES MUST BE PROVIDED WITH NO COST-SHARING?

The new rules require that a group health plan, *at a minimum*, provide coverage for the following four categories of preventive services (referred to in this *Commentary* as "mandated services") and do so *without any cost-sharing*:

- Services that have been recommended by the United States Preventive Services Task Force ("Task Force") with an A or B rating. There are more than 40 such items, including screening for high blood pressure, diabetes, cancer, sexually transmitted infections, and adolescent depression, and counseling related to BRCA gene screening for hereditary breast and ovarian cancer, alcohol misuse, tobacco cessation, and obesity. [3]
- Routine immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC"). An immunization is considered routine if it appears on the CDC Immunization Schedules.
- Evidence-informed preventive care and screenings for infants, children, and adolescents recommended in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").
- Evidence-informed preventive care and screenings for women supported by the HRSA and not otherwise addressed by Task Force recommendations. These guidelines are to be developed by the Department of Health and Human Services and are expected to be issued no later than August 1, 2011.

These mandated services are the minimum preventive services that must be provided and for which no cost-sharing requirements may be imposed by the group health plan. A group health plan that has a network of providers is not required to provide any mandated services delivered by out-of-network providers. If the plan covers mandated services provided by out-of-network providers, it is permitted to impose cost-sharing requirements for such services. Further, a treatment that results from a mandated service, but is not itself on the mandated service list, may be subject to the plan's cost-sharing requirements.

The regulations do not offer guidance as to whether *every* group health plan sponsored by an employer must independently meet these minimum requirements or whether plans may be aggregated to meet the requirements. For example, many employer group health programs offer tobacco cessation, obesity, and nutritional counseling at no cost to employees through an employee assistance program ("EAP") and supplemental treatment for these conditions to plan participants under the medical plan if the nature of the condition requires more intensive services. It is not clear from the regulations whether, in this example, the group health plan may be treated as comprising both the EAP and the medical plan for purposes of determining whether the mandated services are being provided. The Departments are developing additional guidelines regarding the utilization of value-based insurance designs by group health plans with respect to preventive services, and they are seeking comments related to the development of such guidelines for value-based designs that promote a choice of providers offering the best value and quality for preventive services. Until such guidance is issued, however, employers will not know whether preventive counseling services will have to continue to be offered under a health benefit plan if the employer offers such services without a fee under other programs of the employer.

HOW ARE THE RESTRICTIONS ON COST-SHARING APPLIED WHEN MANDATED SERVICES ARE PROVIDED IN CONNECTION WITH AN OFFICE VISIT?

The new regulations prohibit cost-sharing requirements such as co-payments, co-insurance, and deductibles with respect to the mandated services. However, because preventive services are often provided in connection with a physician office

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3 The recommendations of the Task Force regarding breast cancer screening, mammography, and prevention, which were issued in or around November 2009, are *not* considered to be current; rather, the mandated services that are required to be covered without cost-sharing are the Task Force recommendations regarding breast cancer screening, mammography, and prevention issued in 2002.

visit, the regulations provide guidance as to when a group health plan can impose a cost-sharing requirement on the office visit.

- When the office visit and the mandated services are *billed separately*, the group health plan may impose cost-sharing on the office visit but may not impose cost-sharing on the mandated services.
- When the office visit and the mandated services are *not* billed separately and the delivery of the mandated services is the *primary purpose* of the office visit, the group health plan may *not* impose cost-sharing on the office visit.
- When the office visit and the mandated services are *not* billed separately and the delivery of the mandated services is *not* the primary purpose of the office visit, the group health plan may impose cost-sharing on the office visit.

The following examples, based on examples in the interim final regulations, illustrate these rules:

Example #1: A 40-year-old male who is a participant in a group health plan visits an in-network health care provider. The individual is screened for cholesterol abnormalities, a service that currently has an A rating under the recommendation of the Task Force for men aged 35 and older. The provider bills the plan separately for the office visit and for the cholesterol screening lab work.

Conclusion: The plan may not impose cost-sharing requirements on the participant with respect to the separately billed lab work. Because the office visit is billed separately, the plan may impose cost-sharing for the office visit. Additionally, if a treatment is prescribed as a result of the screening, but is not included in the list of mandated services, the group health plan may impose cost-sharing for that treatment.

Example #2: A child covered by a group health plan visits an in-network pediatrician for the purpose of receiving an annual physical exam. An annual physical exam is a mandated service because it is part of the comprehensive guidelines of the HRSA. During the office visit, the child receives additional services that are not mandated services. The provider bills the plan for an office visit.

Conclusion: Although the mandated services and additional services were billed together, because the primary purpose of the office visit was to deliver mandated services (an annual physical exam), the plan may not impose cost-sharing for the office visit.

CAN A GROUP HEALTH PLAN COVER ADDITIONAL PREVENTIVE SERVICES OR ADD LIMITATIONS THAT ARE NOT RELATED TO COST-SHARING?

A group health plan may provide coverage for additional preventive services (*e.g.*, more frequent screenings for cervical cancer than is mandated under the regulations) and may also impose cost-sharing requirements on participants who use the additional services.

If the recommendations and guidelines adopted by the Task Force, CDC, or HRSA do not include sufficient detail with respect to the frequency, method, treatment, or setting for an item or service, the group health plan may use "reasonable medical management techniques" to determine coverage limitations without imposing cost-sharing requirements. The term "reasonable medical management techniques" is not defined in the regulations. The preamble to the regulations states that a group health plan "may rely on established techniques and the relevant evidence base to determine the frequency, method, treatment, or setting for which a … [mandated] service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline" adopted by the Task Force, CDC, or HRSA.

HOW OFTEN ARE GROUP HEALTH PLANS REQUIRED TO BE UPDATED TO REFLECT CHANGES MADE TO THE LIST OF MANDATED SERVICES?

A group health plan is required to cover and eliminate cost-sharing for newly added mandated services no later than the first plan year beginning on or after the date that is one year after the new recommendations or guidelines are accepted or adopted by the Task Force, CDC, or HRSA. For example, for the plan year beginning on January 1, 2011, the mandated services covered by the group health plan must reflect recommendations and guidelines issued on or before

January 1, 2010. When changes or additions to the list of mandated services are accepted or adopted as recommendations or guidelines by the Task Force, CDC, or HRSA, they will be posted online at http://www.HealthCare.gov/center/regulations/prevention.html. The online information will also include the date on which the recommendation or guideline was accepted or adopted to facilitate determining which mandated services must be covered with no cost-sharing for each plan year.

However, plans may eliminate coverage and add cost-sharing prior to the beginning of the next plan year if a mandated service is eliminated from the recommendations or guidelines described above (*e.g.*, the Task Force downgrades a screening from B to C). Of course, other state and federal law requirements must be met. For example, for an insured plan, state law may require continued coverage of the service. In addition, beginning March 23, 2012, under PPACA, a group health plan will be required to give 60 days' advance notice to a participant before any material modification will become effective.

NEXT STEPS

Employer plan sponsors should begin working with their health plan insurers and administrators to ensure that, if the group health plan is not grandfathered, the mandated services are provided under the group health plan without any cost-sharing requirements. If an employer's group health plan is a grandfathered plan, now is the time to determine whether the employer desires to voluntarily comply with the new PPACA rules and the indirect impact such voluntary compliance may have on its ability to retain grandfathered status.[4] Many employers (either because of their size or location) may not have direct control over this level of plan design and will be relying on the issuer of the insurance policy or the health plan administrator to comply with these new rules. It is too early to tell whether employers will be offered one-size-fits-all preventive services coverage or separate plan designs (and separate cost structures) for grandfathered and nongrandfathered group health plans.

This is one in a series of *Commentaries* Jones Day intends to provide to our clients and friends on the provisions of PPACA. We will provide additional guidance on how the provisions of PPACA, and the developing regulatory framework, affect employer-sponsored health plans and their sponsoring employers as developments occur.

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4 Voluntary compliance with PPACA, by itself, will not cause a group health plan to lose grandfathered status. Other changes, however, such as a significant decrease in the employer's contributions from March 23, 2010 levels that may indirectly result from increased costs associated with voluntary compliance with this and other new mandates, may cause the group health plan to eventually lose grandfathered status.