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BENEFIT NEWS BRIEFS

Final Regulation on Coverage of Certain Preventive Services Under the ACA

The Department of the Treasury; Department of Labor; and the Department of Health and Human Services (collectively "the Departments") jointly issued a final regulation regarding coverage of certain preventive services under the *Affordable Care Act (ACA).* The reader may recall that the *ACA* requires coverage of certain preventive health services without cost sharing by non-grandfathered group health plans and health insurance coverage.

The final regulations adopt the various proposed and interim preventive care regulations and also incorporate some of the clarifications that were announced in *ACA* FAQs so few operational changes will be necessary for plans that have kept abreast of matters. A redline of the relevant changes to the regulations text, as discussed below, is available by "*clicking here*."

However, the majority of the regulations changes do NOT concern multiemployer group health plans but are directed at accommodations of non-profit religious organizations or closely-held corporations whose owners have sincerely held religious beliefs in conflict with the "contraceptive coverage" requirement for non-grandfathered plans. We will discuss only the few changes that are generally applicable to non-grandfathered self-insured group health plans, including multiemployer plans.

These final regulations are applicable beginning on the first day of the first plan year that begins on or after September 14, 2015.

What preventive services must a non-grandfathered plan cover?

As a refresher, "recommended preventive services" that must be covered with no cost-sharing by non-grandfathered plans include:

- 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 (Task Force) with respect to the individual involved.

Prepared by Mike Ewing, J.D.
Director of Research
United Actuarial Services, Inc.
(317) 580-8659 • Fax (317) 580-8651
email: mewing@unitedactuarial.com

- 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 (Advisory Committee) 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 (CDC). A recommendation is considered to be for "routine use" if it appears on the Immunization Schedules of the CDC.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force), including all Food and Drug Administration (FDA)-approved contraceptives, sterilization procedures, and patient education and counseling for women with reproductive capacity, as prescribed by a health care provider (collectively, contraceptive services).

According to the *Preamble* to the final regulation, the complete list of preventive recommendations and guidelines that are required to be covered under these final regulations can be found at: https://www.healthcare.gov/preventive-care-benefits. More information on related safe harbors, forms, and model notices is available at http://www.dol.gov/ebsa/healthreform, in particular on the "coverage for preventive services" webpage.

What do the final regulations say about "preventive services" and "office visits"?

These final regulations continue to provide that when a recommended preventive service is not billed separately from an office visit (or is not tracked as an individual encounter separately), plans must look to the primary purpose of the office visit when determining whether they may impose cost sharing with respect to the office visit. *Nothing in these requirements precludes a health care provider from providing preventive services, along with other treatment, in a single office visit.*

These rules only establish the circumstances under which an office visit that includes a recommended preventive service may be subject to cost sharing. According to the *Preamble,* the Departments anticipate that the determination of the primary purpose of the visit will be resolved through normal billing and coding activities, as they are for other services.

When must a plan begin covering new A & B recommendations and for how long?

Plans must provide coverage for new recommended preventive services for plan years beginning on or after the date that is one year after the date the relevant recommendation or guideline is issued. Accordingly, the final regulations state that a plan that is required to provide coverage for any recommended preventive service *on the first day of a plan year* under a particular recommendation or guideline must

generally provide that coverage through the last day of the plan year, *even if the recommendation or guideline changes or is eliminated during the plan year.*

However, the *Preamble* notes that there are limited circumstances under which it may be inadvisable for a plan to continue to cover preventive items or services associated with a recommendation or guideline that was in effect on the first day of a plan year or policy year (for example, due to safety concerns). Therefore, the final regulations state that if, during a plan year,

> (1) an "A" or "B" recommendation or guideline of the Task Force that was in effect on the first day of a plan year is downgraded to a "D" rating (meaning that the Task Force has determined that there is strong evidence that there is no net benefit, or that the harms outweigh the benefits, and therefore discourages the use of this service), or
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> (2) any item or service associated with any preventive service recommendation or guideline that was in effect on the first day of a plan year is the subject of a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate that item or service,

there is no requirement under this section to cover these items and services through the last day of the plan or policy year. Should such circumstances arise, the Departments expect to issue subregulatory guidance to this effect with respect to such preventive item or service.

How can a plan sponsor stay current on these preventive services recommendations?

The *Preamble* notes that a list of the recommended preventive services is available at https://www.healthcare.gov/preventive-care-benefits and states that the Departments intend to update this list to include the date on which the recommendation or guideline was accepted or adopted. New recommendations and guidelines will also be reflected on this site.

As noted, plans need not make changes to coverage and cost-sharing requirements based on a new recommendation or guideline until the first plan year beginning on or after the date that is one year after the new recommendation or guideline goes into effect. The goal is that by visiting this site once per year plans should have access to all the information necessary to identify any additional items or services that must be covered without cost sharing, or to identify any items or services that are no longer required to be covered.

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