McGraw Wentworth

REFORM Update

Issue Twelve July 2010

July 20, 2010

Health Care Reform guidelines for preventive care services were released last week by the joint agency taskforce. The guidelines provide an in-depth discussion of the requirements to cover certain preventive care services at 100% including:

- What preventive care services must be covered
- How to apply an office visit copay
- How to update the list of covered services

The regulations clearly aim to increase the use of preventive services in an effort to bend the cost curve down. Coverage for preventive care services is expanded and financial barriers removed in an effort to encourage individuals to access preventive care and health screenings appropriate for their age and health status. The regulations cite studies that found reductions in health cost through early identification and treatment of certain health conditions, as well as studies that found extending coverage to a wider range of preventive screening would saves lives (although the regulations also point out that individuals must take action to get preventive care to achieve the positive benefits).

As a reminder, the preventive care service guidelines become effective on the first day of the first plan year following September 23, 2010. Grandfathered plans can choose to delay the effective date until the point grandfathered status is lost.

## Services Required to Be Covered

The statute set forth a very specific list of services to be covered at 100% with no cost-sharing:

- Evidence-based services rated “A” or “B” by U.S. Preventive Services Task Force
- Immunizations recommended by Advisory Committee on Immunization Practices of CDC
- For infants, children, and adolescents: evidence-informed preventive care and screenings in comprehensive guidelines from Health Resources and Services Administration
- For women: preventive care and screenings not described in point 1 but provided for in comprehensive guidelines supported by Health Resources and Service Administration
- Current recommendations of U.S. Preventive Services Task Force regarding breast cancer screening, mammography and prevention (excluding the November 2009 changes)

The regulations provide a lengthy list of preventive services required for compliance, including:

***Covered Preventive Services for Adults***

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who ever smoked
- Alcohol misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults over 50
- Depression screening for adults
- Type 2 diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults – doses, as well as recommended ages and populations vary:
    - Hepatitis A and Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk

***Covered Preventive Services for Women, Including Pregnant Women***

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast cancer mammography screenings every 1 to 2 years for women over 40

- Breast cancer chemoprevention counseling for women at higher risk
- Breast feeding interventions to support and promote breast feeding
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- Folic acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh incompatibility screening for pregnant women, follow-up testing for those at higher risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Syphilis screening for all pregnant women or other women at increased risk

***Covered Preventive Services for Children***

- Alcohol and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Cervical dysplasia screening for sexually active females
- Congenital hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, weight and body mass index measurements for children
- Hematocrit or hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus Influenzae Type B
    - Hepatitis A and Hepatitis B

  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical history for all children throughout development
- Obesity screening and counseling
- Oral health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

If a health plan has a network of providers, compliance requires coverage in-network with no employee cost-sharing (plans are not compelled to cover any preventive services out-of-network). If a health plan does cover any of these services out-of-network, it is not required to waive out-of-network cost sharing.

In addition, the regulations allow reasonable medical management techniques to determine frequency, method, treatment or setting to receive covered preventive services. This only applies if a frequency for a screening or service is not included in the recommendation or guideline.

Most employer plans cover some level of preventive care services. Typically, plans cover specified services, sometimes with copays and annual maximums as well. With the changes made by health care reform, the plan will likely need to expand covered services to those listed above, remove any annual maximums that apply to the covered services above and theoretically remove any employee cost-sharing (see next section).

Some plans will cover preventive care services not covered by the above list. In this case, the plan can continue covering these services with any required copays and limitations.

## Application of an Office Visit Copay

Anyone who has helped employees with claims over the years realizes the coverage of preventive services is not as cut and dry as it seems. As with all claims, the physician coding guides how the claim will be processed.

The regulations provide a detailed discussion of various situations and how they can be handled by the health plan:

- If preventive service billed separately from office visit, plan can impose office visit cost sharing
- If preventive service not billed separately from office visit and primary purpose of office visit is delivery of preventive service, plan may not impose office visit cost sharing
- If preventive service not billed separately from office visit and primary purpose of the office visit is not delivery of preventive service, plan can impose office visit cost sharing

In addition to the notation above about separate billing, the regulations also refer to whether encounter data is tracked separately to provide guidelines about applied office visit cost sharing to plans and issuers that use capitation or similar payment arrangements (such as an HMO).

The regulations include examples to help illustrate the application of office visit copays:

- Individual visits in-network physician and during visit is screened for cholesterol abnormalities (covered preventive service); provider bills office visit and lab work for cholesterol screening separately so plan must cover lab at 100% but can assess office visit copay for the physician visit
- Individual above is diagnosed with hyperlipidemia and prescribed treatment - follow up visit and treatment not a covered preventive services and plan can assess any applicable cost-sharing
- Individual visits in-network physician to investigate recurring abdominal pain and during visit the individual has blood pressure screening; provider bills all services as office visit so plan can apply office copay (blood pressure screening is a covered preventive service, but primary reason for office visit was abdominal pain)
- Child visits in-network pediatrician to receive annual physical (covered preventive service) and during the visit child receives additional services not considered covered preventive services; provider bills all services as office visit so plan cannot assess office visit copay (primary purpose of office visit was covered preventive service)

As you can see, how the provider codes and bills the service will dictate how that service needs to be paid by the plan.

**Updating the List of Covered Services**

From time to time, preventive care service recommendations change (remember the hullabaloo over changes to mammogram recommendations last year?). The new regulations include guidance on how to handle these changes.

If a service is dropped from recommendations, plans can discontinue covering that service immediately. However, regulations state that a plan may have other guidance to review before dropping coverage and in some cases state law may mandate coverage of a service for fully insured

plans – if so, coverage cannot be dropped. The regulations also note that ERISA requires 60 days notice to plan participants when a benefit change is a reduction of benefits and this would apply to a discontinuance of preventive care service coverage.

If a new service is added to the recommendations, plans have at least a year to adopt coverage for the new recommendations. This will allow plans to annually review the changes to the list of covered preventive services and make any necessary changes.

The list of covered preventive services will be maintained by the government and can be found at http://www.HealthCare.gov/center/regulations/prevention.html.

**Concluding Thoughts**

Since grandfathered plans may delay implementation of the preventive care service rules, the first step for an employer may be to determine whether their plan will maintain grandfathered status. If a plan is grandfathered, these provisions are not required until the plan loses grandfathered status.

Your next step may be to ask your insurance carrier or third party administrator how they plan to handle this expansion of coverage and change in cost-sharing requirements. Since your vendors handle claims payment, they will need to modify systems to ensure that specified preventive services are covered with no cost-sharing. Your vendor should also be able to provide an estimate of the cost affect (increase) affiliated with expanding preventive care coverage.

Finally, you will need to communicate any changes to employees. Most employers include preventive care coverage in their open enrollment newsletters, summary plan descriptions, new hire newsletters, and sometimes company HR intranet sites.

The government and many health experts believe that expansion of preventive coverage will help keep cost down and contribute significantly to plan participants' general health over the long run. The coverage expansion is likely to increase short term health plan costs with the longer term impact difficult to measure and likely to be impacted by factors such as future levels of employee turnover, plan participant usage of preventive care services, and plan participant compliance with recommended treatment.