



## **AHIP Summary of Issues Addressed in Pre-Publication Copy of Interim Final Regulations for Coverage of Preventive Services Under PPACA**

July 14, 2010

On July 14, the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury issued a “[pre-publication](#)” copy of interim final regulations to require coverage of preventive services as required by section 2713 the “Patient Protection and Affordable Care Act” (PPACA). The interim final regulations will be officially published in the *Federal Register* on July 19 and the agencies will be accepting public comments until September 17. AHIP staff will be working with members to draft an industry response.

The interim final regulations apply to group health plans and health insurance coverage issued in the group and individual markets and will be effective for plan or policy years beginning on or after September 23, 2010. (The regulatory requirements do not apply to “grandfathered” health plans as that term is used in PPACA.)

Overall, the regulations require coverage for all of the following items and services, without imposing any cost-sharing requirements (e.g., a copayment, coinsurance, or deductible):

- Evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- 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 (ACIP);
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). (The preamble includes two charts that reference the “Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care,” and the “Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children”); and
- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, as long as they are not otherwise addressed by the recommendations of the USPSTF. (HHS is developing these guidelines and expects to issue them no later than August 1, 2011.).

These categories address a broad category of preventive services including immunizations, blood pressure and cholesterol screenings, diabetes screening for hypertensive patients, various cancer and sexually transmitted infection screenings, genetic testing for the BRCA gene, depression

screening, tobacco cessation, obesity screening and counseling, as well as other services. The complete list of recommendations and coverage guidelines is available at <http://www.HealthCare.gov/center/regulations/prevention.html>.

Recognizing that health insurance plans have always looked to the USPSTF and ACIP for guidance on appropriate clinical preventive services and immunization recommendations, these regulatory provisions and agency explanations are a positive step forward to encourage adoption of evidence-based medicine and for increasing access to evidence-based clinical preventive services.

In addition, the preamble and the regulations provide several important clarifications to interpret the regulatory provisions:

- **Billing and Office Visits.** Plans and issuers may not impose cost-sharing requirements for office visits if a recommended preventive service is: (1) not billed separately (or is not tracked separately as individual encounter data) from an office visit; and (2) the primary purpose of the visit is the delivery of a preventive item or service. However, a plan or issuer may impose cost-sharing requirements for an office visit if: (1) a recommended preventive service is billed separately from an office visit, or is tracked separately as individual encounter data; or (2) a recommended preventive service is not billed separately or is not tracked separately as individual encounter data but the primary purpose of the office visit is the delivery of a health care item or service unrelated to a preventive service.
- **Out of Network Charges.** Plans and issuers are not required to provide coverage for recommended preventive services delivered by out-of-network providers. In these situations, plans and issuers may impose cost-sharing requirements for recommended preventive services.
- **Medical Management.** Plans and issuers can use reasonable medical management techniques to determine coverage limitations if a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service. The preamble to the regulations explains that “a plan or issuer may rely on established techniques and the relevant evidence base to determine the frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.”
- **Benefits and Treatment.** The agencies recognize that many plans and issuers currently cover preventive services and, in some cases, provide coverage for preventive services that go beyond those recommended by the USPSTF, HRSA, or the ACIP. The preamble to the regulations explains that both the statute and the interim final regulations allow plans and issuers the option to cover preventive services that are in addition to those required by §2713. For such additional preventive services, plans and issuers may

impose cost-sharing requirements. In addition, a plan or issuer may impose cost-sharing requirements for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

- **Changes to Recommended Preventive Services.** The interim final regulations make clear that a plan or issuer is not required to provide coverage or waive cost-sharing requirements for any item or service that ceases to be a recommended preventive service.
- **Value-Based Insurance Designs.** The agencies have interpreted PPACA as granting them authority to develop guidelines for group health plans and health insurance issuers offering group or individual health insurance coverage that utilize value-based insurance designs as part of their offering of preventive health services. The agencies are developing additional guidelines for value-based insurance designs and preventive benefits. Public comments are being sought that specifically address how these guidelines should be developed and to promote consumer choice of providers or services that offer the best value and quality, and ensure access to critical, evidence-based preventive services.
- **Timelines for Adding New Recommendations.** The agencies have interpreted the statute as requiring the Departments to establish an interval of not less than one year between when the recommendations are issued (for example, when the USPSTF recommendations are published or publicly released) and the plan year/policy year for which coverage of the services addressed in such recommendations must be in effect.

The agencies anticipate four benefits will result from the regulatory requirements: (1) individuals will experience improved health as a result of reduced transmission, prevention or delayed onset, and earlier treatment of disease; (2) healthier workers and children will be more productive with fewer missed days of work or school; (3) some of the recommended preventive services will result in savings due to lower health care costs; and (4) the cost of preventive services will be distributed more equitably. However, the preamble recognizes that State laws may have an impact on realizing these benefits and how entities address the federal regulatory provisions, since States currently have diverse legal requirements in place related to preventive services.