LLB&L Client Alert

May 6, 2010

Under Federal Health Care Reform

Mandated Coverage for Preventive Services – Without Cost-Sharing

Authors

Gail D. Schubert
916-554-0243
gschubert@lockelord.com

Jan Reimann Newsom
214-740-8639
jnewsom@lockelord.com

Kristen H. Cerf
916-554-0247
kcerf@lockelord.com

The mandate to cover preventive services with no cost sharing (the "Preventive Services Mandate") included in the Patient Protection and Affordable Care Act (the "Act") presents one of the many implementation challenges for health insurers and health maintenance organizations (collectively, "Carriers"), as well as for certain self-insured employer plans. The Preventive Services Mandate is intended to eliminate financial barriers to accessibility, enabling individuals to identify health issues early and take appropriate measures to stay healthy or treat problems in the earliest stages. Carriers and plan administrators should be prepared to take quick action to ensure compliance with these new legal requirements by September 23, 2010.

The following areas must be analyzed to implement the Preventive Services Mandate:

- Hundreds of pages of guidelines and recommendations are required by the Act to be used to define preventive services and what must be covered, at a minimum, without cost-sharing;
- Carriers must determine which of their policies, beneficiaries or insureds are covered by the Preventive Services Mandate, and which are covered by grandfathered health plans to which the Preventive Services Mandate does not apply;
- Processes must be implemented to ensure that claims for preventive services provided to beneficiaries or insureds covered by the Preventive Services Mandate are not applied to satisfy a deductible; and
- Participating providers must be educated not to seek collection of copayments or coinsurance from beneficiaries or insureds covered by the Preventive Services Mandate.

Because many Carriers are required to obtain state regulatory approvals for benefit changes, these implementation tasks must be accomplished quickly to obtain the required approvals prior to the September 23, 2010 effective date.

The Law Setting Forth the Preventive Services Mandate

A new Section 2713 was added by the Act to the Public Health Service Act ("Section 2713"), which requires HMOs, health insurance issuers offering group or individual health insurance coverage, and group health plans as defined under the Employee Retirement Income Security Act of 1974 ("ERISA") to provide coverage without imposing any cost sharing requirements for five categories of preventive services. The five categories of preventive services are:

(1) Evidence-based items or services that are rated 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (*See The Guide to Clinical Preventive Services 2009*);

(2) Immunizations that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (*See General Recommendations on Immunization*, *ACIP Recommendations* and *Immunization of Health-Care Workers*);

(3) 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;

(4) With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehen-

www.lockelord.com

This *Client Alert* is provided solely for educational and informational purposes. It is not intended to constitute legal advice or to create an attorney-client relationship. Readers should obtain legal advice specific to their enterprise and circumstances in connection with each of the topics addressed.

If you would like to be removed from our mailing list, please contact us at either unsubscribe@lockelord.com or Locke Lord Bissell & Liddell LLP, 111 South Wacker Drive, Chicago, Illinois 60606, Attention: Marketing. If we are not so advised, you will continue to receive *Client Alerts*.

Attorney Advertising

© 2010 Locke Lord Bissell & Liddell LLP

sive guidelines supported by the Health Resources and Services Administration; and

(5) The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current (other than those issued in or around November 2009).

Additionally, the Secretary of Health and Human Services is required to establish a minimum interval of not less than one year between the date on which a recommendation or guideline described in (1), (2), or (3) above is issued, and the beginning of the plan year with respect to which the requirement for the new or amended recommendation or guideline applies.

Applicable Implementation Date and Grandfathered Health Plans

The Preventive Services Mandate will become effective for plan years beginning on or after September 23, 2010, which is six months after the date of enactment of the Act. However, recalling President Obama's promise to allow Americans with existing coverage to retain that coverage if desired, grandfathered health plans will be able to continue past September 23, 2010, without implementation of the Preventive Services Mandate. Grandfathered health plans are generally those that were in effect on March 23, 2010, the enactment date of the Act. However, we are awaiting the issuance of regulations to clarify whether any changes to the plan, such as premium increases, or changes to implement certain other requirements of the Act, will result in the loss of grandfathered health plan status.

Identifying Preventive Services Claims

Carriers and plan administrators utilize a variety of business models to deliver their group health plans and health insurance coverage across the country. Some contract with large multi-specialty medical groups and hospitals on a capitated basis where the capitated provider is responsible for the payment of claims incurred by the Carrier's beneficiaries or insureds. Others contract directly or through Third Party Administrators ("TPAs") or preferred provider organizations with provider networks which may or may not have claims processing responsibilities. Some products have deductibles that must be met, others do not. Some have office visit copayments that are paid to the provider at the time service is provided. Others have coinsurance that is invoiced to the insured by the provider after the Carrier has determined the correct claims payment, coinsurance amount, and, if applicable, allocation of the provider claim to satisfaction of a deductible.

Regardless of the business model, Carriers, plan administrators or the entities with which they contract to process claims will need to be able to:

(1) Identify a claim that includes preventive services;

(2) Identify whether the beneficiary or insured is covered under a group health plan or health insurance coverage effective September 23, 2010, or later that is subject to the Preventive Services Mandate; and if so

(3) Ensure that the preventive service claim is paid without collection of a copayment or coinsurance from the beneficiary or insured, and without application of the amount of the claim to satisfy a deductible.

Knowing When to Collect a Copayment or Coinsurance

Many Carriers and plan administrators delegate the responsibility to the provider to collect copayments, coinsurance, and charges applied to a deductible. Office visit copayments are particularly troubling because the provider's office staff typically collects the copayment when the patient checks in for the appointment. At that point in time it may not be clear that preventive services will be delivered during the office visit. For example, a patient who is not covered by a grandfathered health plan could make an appointment for examination, possible x-ray, and treatment of an injured ankle. Then during the visit the provider could observe that the patient is not current on immunizations, or a cancer screening is indicated. If the immunization or cancer screening is performed along with diagnosis and treatment of the injured ankle during the visit, should the office visit copayment be charged by the provider? We await guidance in the regulations currently in development in order to answer these questions.

Next Steps

The Preventive Services Mandate will apply to new individual and group health insurance policies, HMO policies, and group health plans for self-insured employers covered under ERISA with plan years beginning on or after September 23, 2010. Carriers and plan administrators will need to: (1) develop methods for identifying which beneficiaries and insureds are covered by the Preventive Services Mandate, and which are covered under grandfathered health plans; (2) instruct providers on how to identify preventive services under the Act so that copayments and coinsurance amounts will not be collected for the pro-

Offices

Atlanta

Austin

Chicago

Dallas

Houston

London

Los Angeles

New Orleans

New York

Sacramento

San Francisco

Washington, DC

Under Federal Health Care Reform (cont'd.)

vision of these services to impacted beneficiaries and insureds; and (3) instruct entities who process claims subject to the Preventive Services Mandate on how to: (a) calculate the amount due to the provider for preventive services claims to include any necessary adjustments for amounts that previously would have been collected as copayments or coinsurance from the beneficiary or insured; and (b) identify the preventive services claims that can no longer be applied towards a deductible.

After developing business plans and supportive documents to accomplish the steps above, Carriers and plan administrators will need to determine for each line of business or product whether state or federal regulatory filings are required. Such filings may include revised insurance policies, subscriber agreements, summary plan descriptions, evidences of coverage, disclosure forms, policy certificates, provider contracts, TPA agreements, and advertisements, as well as premium rate increases. All regulatory filings should be filed as soon as possible to give the regulatory agency staff time to review and approve the filings prior to the September 23, 2010 effective date of the Preventive Services Mandate. After this date, all new group health plan and health insurance coverage issued to new subscribers, employers, or insureds must comply with the Preventive Services Mandate.

About the Authors

Gail D. Schubert represents medical, behavioral health, dental and vision HMOs, as well as insurance companies, pharmacies, and other health care organizations in California and in several other states. She has extensive experience with licensure and regulatory filings with the California Department of Managed Health Care, or DMHC, for health plans regulated under the Knox-Keene Act. Ms. Schubert regularly represents clients in front of the DMHC to obtain approvals for cutting-edge products, unusual restructurings, changes in control, outsourcing arrangements, exemption requests, discount plans, and other challenging regulatory initiatives.

Ms. Schubert started the Sacramento office of a Los Angeles-based law firm in 1998, and joined Locke Lord in 2006. Prior to that she served as Vice President and Counsel for Foundation Health Systems, and as Lead Counsel in the California Department of Corporations, the predecessor agency to the DMHC. Ms. Schubert's depth of experience as a regulator, an in-house lawyer, and a law firm lawyer representing a variety of managed care entities gives her the full range of operational and legal expertise to achieve successful business solutions to legal and regulatory issues.

Jan Reimann Newsom is senior counsel at Locke Lord. She has extensive experience in health care law with a focus on health care utilization management and quality assurance, peer review, licensing and credentialing and third party administration matters. She also concentrates on HIPAA, Medicare and Medicaid reimbursement issues, Stark law and fraud and abuse compliance, illegal remuneration and compensation matters.

Kristen H. Cerf is an associate in Locke Lord's Sacramento office, where she practices health care and insurance law and general civil litigation. Her health care and insurance practice focuses on federal and state regulatory and compliance matters for insurance companies and full-service and specialized health care service plans, as well as other health care organizations, such as provider groups and pharmacies.

© 2010 Locke Lord Bissell & Liddell LLP