

Health Reform Update- July 2010

Interim Final Regulations Issued on Copayment Limitations for Preventive Care

The US Departments of Labor and Health and Human Services jointly issued interim final rules on July 19th that clarify the requirement in recent federal health reform legislation regarding coverage of preventive health services.

What does the new rule say about coverage for preventive services?

The new federal law states that newly offered health plans must cover certain preventive services without co-payments or cost sharing, in the plan years (in the individual market, policy years) that begin on or after September 23, 2010. These rules do not apply to “grandfathered” health plans.

Both fully insured and self-insured employer-sponsored plans are subject to the federal law and rules, as described above.

How do I know if I have a “grandfathered plan” that is exempt from these rules?

Your plan is a “grandfathered plans” if it was in effect on the day the law passed (3/28/2010), and you do not significantly change copayment, deductible or premium-sharing requirements between now and 2014. However, a new plan (a plan that wasn’t in effect on 3/28/2010) or an “old” plan that loses “grandfathered status” because of significant changes to cost sharing requirements, will be subject to these new rules. So, your plan may be exempt now but would be subject to the rules if you make significant changes to the plan in the future. (FJG has a fact-sheet with more details on the recently issued regulations on what constitutes “significant changes” that would trigger a loss of grandfathered status.)

What preventive services must be offered without cost sharing?

The law target the mandate to preventive services for which there is scientific evidence of cost-effectiveness, and which have been recommended by special task forces of the Public Health Service, the Centers for Disease Control, and the Bright Futures program of the Health Resources and Services Administration (which recommends best practices for well child and pediatric care.) In order to be included in this mandate, the recommended services must have scored either an “A” or “B” cost effectiveness rating in these scientific reviews.

The complete list (which is lengthy) can be found here>>

[U.S. Preventive Services Task Force Recommendations](#)

Some of the screenings and immunizations are already fairly widely used (screenings for high blood pressure, mammograms, influenza vaccines for children and seniors). Others may not be so well known or used (e.g. “one time screening for abdominal aortic aneurysm by ultrasound in men aged 65-75 who have ever smoked”).

One of the key issues clarified in the new regulations is that health insurers and plans may require that the services be received within a provider network in order to be received without cost sharing. Services obtained out-of-network may be subject to cost sharing. This provision will allow health plans to mitigate the cost impact of this mandate by negotiating volume-discounts with network providers, and contracting in advance for allowable charges.

The regulations also state that if a preventive service is billed separately from a concurrent office visit, the office visit may still be subject to cost sharing. For example, if a covered immunization is provided during an office visit and the two are itemized separately, a copay may be charged for the office visit, but not for the recommended immunization.

Finally, the regulations provide that co-sharing may apply to a treatment that results from a screening, if the treatment itself is not one of the preventive services. For example, if the screening ultrasound mentioned above does indeed reveal an abdominal aortic aneurism, the surgical treatment for the aneurism will be subject to the plan’s usual cost sharing requirements. Only the preventive screening is exempt from cost-sharing.

When does this take effect?

The requirement takes effect with the beginning of the next plan year that starts after September 28, 2010 (six months after passage of the federal law). Thus, if your plan year started on July 1, the change would take effect next July 1, 2011. If your plan year starts January 1, the change takes effect January 1, 2011. If, however, your plan year starts October 1, the change takes effect this year: October 1, 2010.

What will be the impact on health insurance premiums?

The size of the increase will depend on how many of these screenings and treatments are already 100% covered in your health plan. Some national estimates say the average cost impact will be 1.5% increase, but in Vermont, where state law already mandates low or no cost-sharing for mammography and colonoscopy (the two most frequent screenings), and plans tend to have low cost sharing for well child care, the impact could be lower.

How much will be saved through prevention and early detection is hotly debated. The

hope for long-term cost reduction is reflected in the statement issued by First Lady Michelle Obama said in remarks along with the release of the regulations. “We know that the best way to keep our families healthy and cut health care costs is to keep people from getting sick in the first place.”

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