Segal Consulting

update

Public Sector Benefits Compliance News

July 20, 2015

Departments Publish Final Rule on Required Preventive Services Under the Affordable Care Act

The Affordable Care Act[1] requires non-grandfathered health plans to provide certain preventive services in network without charge to the participant or beneficiary.[2] On July 14, 2015, the Departments of Labor, Treasury, and Health and Human Services (the "Departments"), which are responsible for implementing group health plan standards under the Affordable Care Act, published a final rule clarifying certain issues.[3] The final rule applies to the plan year beginning on or after September 14, 2015 (*i.e.*, January 1, 2016, for calendar-year plans).

This *Update* summarizes the changes in the governing regulations and what plan sponsors should do to stay current.

Health Compliance News:

Background

The preventive services that must be provided without cost sharing fall into four different categories: services with an "A" or "B" recommendation from the U.S. Preventive Services Task Force (USPSTF), vaccines recommended by the Centers for Disease Control and Prevention (CDC), the Bright Futures guidelines developed by the American Academy of Pediatrics with support from the Health Resources and Services Administration (HRSA), and certain women's services listed in HRSA guidelines (supplementing some of the USPSTF recommendations).

Changes in the Governing Regulations

The final rule makes three changes to the governing regulations:

- If a plan's network does not have a provider who can provide a required item or service, the plan must cover that item or service when provided or performed

[1] The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

[2] For background on the preventive services requirements, see Segal Consulting's March 12, 2013 *Capital Checkup*, "New Guidelines on Preventive Care Benefits for Non-Grandfathered Plans."

[3] The final rule was published in the July 14, 2015 *Federal Register*. The final rule also addresses how the Departments will define a closely held for-profit entity that may seek a religious accommodation in connection with the otherwise applicable requirement to provide free contraceptive services to women. For a summary of that aspect of the final rule, see the "Accommodation for Certain Religious Organizations" section of the version of this *Update* for sponsors of single-employer, private sector plans which begins on page 2. For information on the latest answers to frequently asked questions (FAQs) about the contraceptive coverage requirement, see Segal's May 28, 2015 *Update*, "Additional Coverage Required for Preventive Services Under the Affordable Care Act."

by an out-of-network provider, and may not impose cost sharing for that item or service.

- Rules issued in 2010 provide that if a recommended preventive service does not include specific frequency, method, treatment or setting rules for the provision of that service, a plan sponsor can use reasonable medical management techniques to determine any coverage limitations. The new final rule clarifies that plan sponsors may continue to rely on the relevant clinical evidence base and established reasonable medical management techniques, and do not generally have to defer to the recommendations of a treating physician.[4]
- Rules issued in 2010 state that plan sponsors may stop providing an item or service once the underlying guideline or recommendation has been changed. The new final rule requires that plan sponsors continue to provide the coverage (without cost sharing) through the end of the plan year, except when the USPSTF has downgraded the recommendation from "A" or "B" to "D" or there is a safety concern. The Departments intend to issue guidance if these types of situations arise.

The Departments previously addressed the first two in answers to FAQs.

How to Stay Current

Plan sponsors may want to visit the healthcare.gov website once each year to access the information that is necessary to identify any new items or services that must be provided. HHS intends to update this list to include the date on which each existing recommendation or guideline was issued. HHS will also include new recommendations or guidelines. The general rule is that plan sponsors must provide the required item or service starting with the plan year that begins one year after the recommendation or guideline is issued.

In the past, this website has not kept pace with newly issued recommendations. It also has not reflected the detailed guidance provided in answers to FAQs, so plan sponsors will likely need to continue to monitor FAQs for guidance on these requirements.

Implications for Plan Sponsors

Plan sponsors with non-grandfathered plans must take steps to ensure that those plans are administered consistently with the new final rule. They should monitor the preventive benefits page at healthcare.gov at least annually, and assure that plan administrators are properly covering in-network preventive benefits without participant cost sharing.

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[4] As summarized in the FAQs discussed in Segal's May 28, 2015 *Update*, there will be situations where a plan sponsor will need to yield to the judgment of the patient's attending provider (*e.g.,* when a provider recommends a particular contraceptive item or service as medically necessary).

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If you would like additional information about this news, please contact your Segal consultant or the Segal office nearest you. Segal can be retained to work with plan sponsors and their attorneys on compliance issues.

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