



Preventive Services - Coverage at 100%

Client Bulletin Provided by HUB International

June 7, 2010

New requirement will increase group health plan costs

Section 2713 of the PPACA (the new health care reform law) requires coverage of certain preventive health services with no cost sharing. In other words, these screenings, tests, immunizations, and other services must be covered at 100%, with no application of deductibles and co-payments or co-insurance. The new rule becomes effective for a group health plan on its first plan year on or after October 1, 2010. (A calendar year plan would be subject to the new rule on January 1, 2011, for example.)

The required coverages are the minimum a plan must provide. A plan can provide coverage for other types of preventive care (subject to other reform provisions, such as the 40% excise/Cadillac tax on group health plans with a high value, which applies in 2018).

Group health plans must cover those items with an "A" or "B" rating by the United States Preventive Services Task Force. Please see the abridged version of the "Guide to Clinical Preventive Services 2009: Recommendations of the U.S. Preventive Services Task Force" at www.ahrq.gov/clinic/pocketgd09. The guidelines provided are arranged by type of test, treatment, or condition, not by the "A" through "I" ratings. Also, please note the guidelines for any given patient will vary depending on factors specific to that person, such as age and family history.

Note: The health reform law states that breast cancer screenings, mammography, and other related guidelines will be determined without regard to the controversial recommendations the Task Force made in November 2009. Otherwise, those 2009 recommendations would have significantly restricted group health plan coverage for mammograms.

Plans are given a period to phase in new recommendations, generally one year and perhaps more based on the plan year.

We do not yet have any federal agency interpretations on how the rules should be explained to plan participants. Ideally, plan sponsors would be permitted to incorporate these guidelines by reference, but the agencies may require plan documents and summaries to list at least some part of the preventive care guidelines by subject heading.

Providing benefit coverage for these additional services will increase group health plan costs. Some of the required services are quite expensive. For example, the grade B is given to certain genetic testing, so the law will require 100% plan payment.

Specific concerns regarding costs arise from the scope of other services -- beyond these “A” and “B” items -- that will be mandated by the federal government for 100% payment. For example, immunizations and screenings for children are not limited to those items selected by this Task Force. The law also references Centers for Disease Control and Prevention recommendations for immunizations, and HHS guidelines for screenings for children. The HHS also is given the power to require additional screenings and preventive care for women.

The Task Force recommendations will become political as more people are aware of the guidelines. Concerns and debates about rationing through federal health reform may arise again, as individuals realize services and screenings lose their recommendation status as “A” or “B” as the patient ages.

Various carriers, including some of the Blue Cross organizations, are lobbying the federal agencies to not expand the recommendations for women and to reassess those for children. In addition, carriers are expressing concern about the wisdom of including coverage for certain genetic testing as grade B items. These tests traditionally have not been covered, in part because the information that is generated by the screenings may not be actionable.