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ACA FAQS PART XII – PREVENTIVE CARE RULES

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As discussed in our prior post, the Department of Treasury/IRS, Department of Labor, and the Department of Health and Human Services (the "Departments") recently issued its twelfth set of Frequently Asked Questions addressing cost-sharing limitations and a slew of preventive services issues. The cost-sharing rules are covered in our prior post; here, we'll discuss the preventive care rules. By way of reminder, non-grandfathered group health plans are required to cover specified preventive services. The FAQs address some open questions that were not addressed in the regulations.

Out-of-Network Services. A plan with a network is generally not required to cover preventive services out-of-network without cost-sharing. However, if a preventive service is not available from any in-network provider, then the FAQs say a plan cannot impose cost-sharing when it is obtained from an out-of-network provider.

Over-the-Counter Medications. The FAQs make clear that plans do have to cover OTC items and services that are part of the preventive care recommendations (e.g. aspirin for those at risk for heart disease), unless those items or services are prescribed by a health care provider.

Polyps. The FAQs state that if a polyp is removed as part of a colonoscopy, the plan may not impose cost-sharing for the polyp removal. The Departments based their determination on clinical practice and comments from various professional medical associations indicating that polyp removal is an integral part of a colonoscopy.

In contrast, plans can impose cost-sharing for a treatment that is not a specified preventive service, even if it results from a preventive service. Presumably, this means that if the results of the colonoscopy, for example, led to a diagnosis of cancer and subsequent treatment, that those treatments could be subject to cost-sharing.

BRCA/Breast Cancer Genetic Testing. Among the specified preventive services are those given an A or B rating by the US Preventive Services Task Force (the "USPSTF"). The USPSTF requires a referral for genetic counseling and "evaluation for" BRCA testing for women who have a family history of breast cancer. However, it was unclear whether the actual genetic test itself was required to be covered without cost-sharing. The FAQs confirm that it is.

Services for "High-Risk" Individuals. If an individual is determined to be at a "high-risk" for a particular disease by his or her provider, plans must cover the preventive services that the USPSTF recommends for those high-risk individuals.

Vaccinations. Another category of preventive services is vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). The ACIP's recommendations are not always general; they could apply to particular age groups or individuals with underlying medical conditions. The bottom line here, as with the high-risk individuals, is that if the provider says they meet the criteria for the ACIP's recommendation, the plan must cover it in-network without cost-sharing.

Well-Woman Visits. The FAQs do not provide much additional detail on what constitutes a "well-woman" visit, other than to say that it includes preventive services approved by the Health Resources and Services Administration (HRSA). However, the FAQs do state that if a provider believes multiple visits are required, then the plan/policy must cover all visits without cost-sharing.

Contraceptives. The FAQs confirm that plans/policies may not limit contraceptive coverage only to oral contraceptives. Plans/policies have to cover the full range of FDA-approved contraceptive methods (barrier, hormonal, and implanted devise, as well as patient education and counseling, as prescribed by a health care provider). Over-the-counter contraceptives only have to be covered if they are FDA-approved and prescribed by a physician.

The FAQs provide that plans may cover a generic or specified brand contraceptive without cost-sharing and impose cost-sharing for other brand name contraceptives. However, if a woman cannot take the generic or preferred brand name drug because it is medically inappropriate (as determined by the health care provider), then the plan/policy must cover the non-preferred brand name drug without cost sharing. This is consistent with the earlier FAQs on value-based insurance design, and one we always felt was a reasonable position based on existing guidance, but it is a welcome clarification.

The FAQs also state that the contraceptive coverage requirement also extends to services related to follow-up and management of side effects, counseling for continued adherence, and device removal for those types of contraceptives.

Breastfeeding counseling. In addition, the FAQs confirm that plans/policies are required to cover interventions during pregnancy and after birth to promote and support breastfeeding. The Departments declined to state how certified lactation consultants could be reimbursed stating that reimbursement policy is "outside the scope" of the guidelines or the regulations. The FAQs require coverage for lactation support, counseling, and costs of renting or purchasing breastfeeding equipment for the duration of breastfeeding. However, plans may use reasonable medical management techniques, as with other preventive services.

Bottom Line. The FAQs illustrate the somewhat uncomfortable fit between some of the guidelines and the workings of health plans/policies. The guidelines are mostly directed at providers, not at plans and policies. Therefore, applying them to plans and policies results in providers having a lot of power to determine what a plan/policy has to cover without cost-sharing.

In addressing these preventive services in plan documents, plan sponsors should be careful not to simply refer to the preventive care regulations or regurgitate the statute. It is important to preserve the right to impose reasonable medical management techniques (which the insurer or TPA should be equipped to handle). In addition, for plan sponsors who chose to cover only certain types of contraceptives, they should be sure the plan provides them the flexibility to do that as well.
