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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[TD 9493]
RIN 1545-BJ60

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210-AB44

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[OCII0-9992-IFC]

45 CFR Part 147

RIN 0938-AQ07

Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Office of Consumer Information and Insurance Oversight, Department of Health and Human Services.

ACTION: Interim final rules with request for comments.

SUMMARY: This document contains interim final regulations implementing the rules for group health plans and health insurance coverage in the group and individual markets under provisions of the Patient Protection and Affordable Care Act regarding preventive health services.

DATES: Effective date. These interim final regulations are effective on September 17, 2010.

Comment date. Comments are due on or before September 17, 2010.

Applicability dates. These interim final regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after September 23, 2010. These interim final regulations generally apply to individual health insurance issuers for policy years beginning on or after September 23, 2010.

ADDRESSES: Written comments may be submitted to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments. Please do not submit duplicates.

All comments will be made available to the public. WARNING: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Department of Labor. Comments to the Department of Labor, identified by RIN 1210-AB44, by one of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>.

Follow the instructions for submitting comments.

E-mail: E-OHPSCA2713.EBSA@dol.gov.

Mail or Hand Delivery: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N-5653, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210, Attention: RIN 1210-AB44.

Comments received by the Department of Labor will be posted without change to <http://www.regulations.gov> and <http://www.dol.gov/ebsa>, and available for public inspection at the Public Disclosure Room, N-1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW., Washington, DC 20210.

Department of Health and Human Services. In commenting, please refer to file code OCII0-9992-IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the instructions under the "More Search Options" tab.

2. By regular mail. You may mail written comments to the following address ONLY: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Attention: OCIIO-9992-IFC, P.O. Box 8016, Baltimore, MD 21244-1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the

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following address ONLY: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Attention: OCIIO-9992-IFC, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC--Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the OCIIO drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

Inspection of Public Comments. All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1-800-743-3951.

Internal Revenue Service. Comments to the IRS, identified by REG-120391-10, by one of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Mail: CC:PA:LPD:PR (REG-120391-10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.

Hand or courier delivery: Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG-120391-10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington DC 20224.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW., Washington, DC from 9 a.m. to 4 p.m.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622-6080; Jim Mayhew, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, at (410) 786-1565.

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's Web site (<http://www.dol.gov/ebsa>). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) Web site (http://www.cms.hhs.gov/HealthInsReformforConsume/01_Overview.as) and information on health reform can be found at <http://www.healthreform.gov>.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act (the Affordable Care Act), Public Law 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (the Reconciliation Act), Public Law 111-152, was enacted on March 30, 2010. The Affordable Care Act and the Reconciliation Act reorganize, amend, and add to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans. The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by this reference are sections 2701 through 2728. PHS Act sections 2701 through 2719A are substantially new, though they incorporate some provisions of prior law. PHS Act sections 2722 through 2728 are sections of prior law renumbered, with some, mostly minor, changes.

\1\ The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan," as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insured group health plans.

Subtitles A and C of title I of the Affordable Care Act amend the requirements of title XXVII of the PHS Act (changes to which are incorporated into ERISA section 715). The preemption provisions of ERISA section 731 and PHS Act section 2724 \2\ (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the requirements of part 7 of ERISA and title XXVII of the PHS Act, as amended by the Affordable Care Act, are not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of the Affordable Care Act. Accordingly, State laws that impose on health insurance issuers requirements that are stricter than those imposed by the Affordable Care Act will not be superseded by the Affordable Care Act.

\2\ Code section 9815 incorporates the preemption provisions of PHS Act section 2724. Prior to the Affordable Care Act, there were no express preemption provisions in chapter 100 of the Code.

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The Departments of Health and Human Services, Labor, and the Treasury (the Departments) are issuing regulations in several phases implementing the revised PHS Act sections 2701 through 2719A and related provisions of the Affordable Care Act. The first phase in this series was the publication of a Request for Information relating to the medical loss ratio provisions of PHS Act section 2718, published in the Federal Register on April 14, 2010 (75 FR 19297). The second phase was interim final regulations implementing PHS Act section 2714 (requiring dependent coverage of children to age 26), published in the Federal Register on May 13, 2010 (75 FR 27122). The third phase was interim final regulations implementing section 1251 of the Affordable Care Act (relating to status as a grandfathered health plan), published in the Federal Register on June 17, 2010 (75 FR 34538). The fourth phase was interim final regulations implementing PHS Act sections 2704 (prohibiting preexisting condition exclusions), 2711 (regarding lifetime and annual dollar limits on benefits), 2712 (regarding restrictions on rescissions), and 2719A (regarding patient protections), published in the Federal Register on June 28, 2010 (75 FR 37188). These interim final regulations are being published to implement PHS Act section 2713 (relating to coverage for preventive services). PHS Act section 2713 is generally effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010, which is six months after the March 23, 2010 date of enactment of the Affordable Care Act. The implementation of other provisions of PHS Act sections 2701 through 2719A will be addressed in future regulations.

II. Overview of the Regulations: PHS Act Section 2713, Coverage of Preventive Health Services (26 CFR 54.9815-2713T, 29 CFR 2590.715-2713, 45 CFR 147.130)

Section 2713 of the PHS Act, as added by the Affordable Care Act,

and these interim final regulations require that a group health plan and a health insurance issuer offering group or individual health insurance coverage provide benefits for and prohibit the imposition of cost-sharing requirements with respect to:

Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved.\3\

 \3\ Under PHS Act section 2713(a)(5), the Task Force recommendations regarding breast cancer screening, mammography, and prevention issued in or around November of 2009 are not to be considered current recommendations on this subject for purposes of any law. Thus, the recommendations regarding breast cancer screening, mammography, and prevention issued by the Task Force prior to those issued in or around November of 2009 (i.e., those issued in 2002) will be considered current until new recommendations in this area are issued by the Task Force or appear in comprehensive guidelines supported by the Health Resources and Services Administration concerning preventive care and screenings for women.

Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be ``in effect'' after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention.

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 (HRSA).

With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force). The Department of HHS is developing these guidelines and expects to issue them no later than August 1, 2011.

The complete list of recommendations and guidelines that are required to be covered under these interim final regulations can be found at <http://www.HealthCare.gov/center/regulations/prevention.html>. Together, the items and services described in these recommendations and guidelines are referred to in this preamble as ``recommended preventive services.''

These interim final regulations clarify the cost-sharing requirements when a recommended preventive service is provided during an office visit. First, if a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. Second, if a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit. Finally, if a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. The reference to tracking individual encounter data was included to provide guidance with respect to plans and issuers that use capitation or similar payment arrangements that do not bill individually for items and services.

Examples in these interim final regulations illustrate these provisions. In one example, an individual receives a cholesterol screening test, a recommended preventive service, during a routine office visit. The plan or issuer may impose cost-sharing requirements for the office visit because the recommended preventive service is billed as a separate charge. A second example illustrates that treatment resulting from a preventive screening can be subject to cost-sharing requirements if the treatment is not itself a recommended preventive service. In another example, an individual receives a recommended preventive service that is not billed as a separate charge. In this example, the primary purpose for the office visit is recurring abdominal pain and not the delivery of a recommended preventive service; therefore the plan or issuer may impose cost-sharing requirements for the office visit. In the final example, an individual receives a recommended preventive service that is not billed as a separate charge, and the delivery of that service is the primary purpose of the office visit. Therefore, the plan or issuer may not impose cost-sharing requirements for the office visit.

With respect to a plan or health insurance coverage that has a network of providers, these interim final regulations make clear that a plan or issuer is not required to provide coverage for recommended preventive services delivered by an out-of-network provider. Such a plan or issuer may also impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider.

These interim final regulations provide that if a recommendation or

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guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques to determine any coverage limitations. The use of reasonable medical management techniques allows plans and issuers to adapt these recommendations and guidelines to coverage of specific items and services where cost sharing must be waived. Thus, under these interim final regulations, a plan or issuer may rely on established techniques and the relevant evidence base to determine the frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.

The statute and these interim final regulations clarify that a plan or issuer continues to have the option to cover preventive services in addition to those required to be covered by PHS Act section 2713. For such additional preventive services, a plan or issuer may impose cost-sharing requirements at its discretion. Moreover, a plan or issuer may impose cost-sharing requirements for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

The statute requires the Departments to establish an interval of not less than one year between when recommendations or guidelines under PHS Act section 2713(a) \4\ are issued, and the plan year (in the individual market, policy year) for which coverage of the services addressed in such recommendations or guidelines must be in effect. These interim final regulations provide that such coverage must be provided for plan years (in the individual market, policy years) beginning on or after the later of September 23, 2010, or one year after the date the recommendation or guideline is issued. Thus, recommendations and guidelines issued prior to September 23, 2009 must be provided for plan years (in the individual market, policy years) beginning on or after September 23, 2010. For the purpose of these interim final regulations, a recommendation or guideline of the Task Force is considered to be issued on the last day of the month on which the Task Force publishes or otherwise releases the recommendation; a recommendation or guideline of the Advisory Committee is considered to be issued on the date on which it is adopted by the Director of the Centers for Disease Control and Prevention; and a recommendation or guideline in the comprehensive guidelines supported by HRSA is considered to be issued on the date on which it is accepted by the Administrator of HRSA or, if applicable, adopted by the Secretary of HHS. For recommendations and guidelines adopted after September 23, 2009, information at <http://www.HealthCare.gov/center/regulations/prevention.html> will be updated on an ongoing basis and will include the date on which the recommendation or guideline was accepted or adopted.

\4\ Section 2713(b)(1) refers to an interval between ``the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.'' While the first part of this statement does not mention guidelines under subsection (a)(4), it would make no sense to treat the services covered under (a)(4) any differently than those in (a)(1), (a)(2), and (a)(3). First, the same sentence refers to ``the requirement described in subsection (a),'' which would include a requirement under (a)(4). Secondly, the guidelines under (a)(4) are from the same source as those under (a)(3), except with respect to women rather than infants, children and adolescents; and other preventive services involving women are addressed in (a)(1), so there is no plausible policy rationale for treating them differently. Third, without this clarification, it would be unclear when such services would have to be covered. These interim final regulations accordingly apply the intervals established therein to services under section 2713(a)(4).

Finally, these interim final regulations make clear that a plan or issuer is not required to provide coverage or waive cost-sharing requirements for any item or service that has ceased to be a recommended preventive service.\5\ Other requirements of Federal or State law may apply in connection with ceasing to provide coverage or changing cost-sharing requirements for any such item or service. For example, PHS Act section 2715(d)(4) requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective.

\5\ For example, if a recommendation of the United States Preventive Services Task Force is downgraded from a rating of A or B to a rating of C or D, or if a recommendation or guideline no longer includes a particular item or service.

Recommendations or guidelines in effect as of July 13, 2010 are described in section V later in this preamble. Any change to a

recommendation or guideline that has--at any point since September 23, 2009--been included in the recommended preventive services will be noted at <http://www.HealthCare.gov/center/regulations/prevention.html>. As described above, new recommendations and guidelines will also be noted at this site and plans and issuers need not make changes to coverage and cost-sharing requirements based on a new recommendation or guideline until the first plan year (in the individual market, policy year) beginning on or after the date that is one year after the new recommendation or guideline went into effect. Therefore, by visiting this site once per year, plans or issuers will have straightforward access to all the information necessary to determine any additional items or services that must be covered without cost-sharing requirements, or to determine any items or services that are no longer required to be covered.

The Affordable Care Act gives authority to the Departments to develop guidelines for group health plans and health insurance issuers offering group or individual health insurance coverage to utilize value-based insurance designs as part of their offering of preventive health services. Value-based insurance designs include the provision of information and incentives for consumers that promote access to and use of higher value providers, treatments, and services. The Departments recognize the important role that value-based insurance design can play in promoting the use of appropriate preventive services. These interim final regulations, for example, permit plans and issuers to implement designs that seek to foster better quality and efficiency by allowing cost-sharing for recommended preventive services delivered on an out-of-network basis while eliminating cost-sharing for recommended preventive health services delivered on an in-network basis. The Departments are developing additional guidelines regarding the utilization of value-based insurance designs by group health plans and health insurance issuers with respect to preventive benefits. The Departments are seeking comments related to the development of such guidelines for value-based insurance designs that promote consumer choice of providers or services that offer the best value and quality, while ensuring access to critical, evidence-based preventive services.

The requirements to cover recommended preventive services without any cost-sharing requirements do not apply to grandfathered health plans. See 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140 (75 FR 34538, June 17, 2010).

III. Interim Final Regulations and Request for Comments

Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS

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Act authorize the Secretaries of the Treasury, Labor, and HHS (collectively, the Secretaries) to promulgate any interim final rules that they determine are appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B of title I of ERISA, and part A of title XXVII of the PHS Act, which include PHS Act sections 2701 through 2728 and the incorporation of those sections into ERISA section 715 and Code section 9815.

In addition, under Section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 551 et seq.) a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. The provisions of the APA that ordinarily require a notice of proposed rulemaking do not apply here because of the specific authority granted by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act. However, even if the APA were applicable, the Secretaries have determined that it would be impracticable and contrary to the public interest to delay putting the provisions in these interim final regulations in place until a full public notice and comment process was completed. As noted above, the preventive health service provisions of the Affordable Care Act are applicable for plan years (in the individual market, policy years) beginning on or after September 23, 2010, six months after date of enactment. Had the Departments published a notice of proposed rulemaking, provided for a 60-day comment period, and only then prepared final regulations, which would be subject to a 60-day delay in effective date, it is unlikely that it would have been possible to have final regulations in effect before late September, when these requirements could be in effect for some plans or policies. Moreover, the requirements in these interim final regulations require significant lead time in order to implement. These interim final regulations require plans and issuers to provide coverage for preventive services listed in certain recommendations and guidelines without imposing any cost-sharing requirements. Preparations presumably would have to be made to identify these preventive services. With respect to the changes that would be required to be made under these interim final regulations, group health plans and health insurance issuers subject to these provisions have to be able to take these changes into account in establishing their premiums, and in making other changes to the designs of plan or policy benefits, and these premiums and plan or policy changes would have to receive necessary approvals in advance of the plan or policy year in question.

Accordingly, in order to allow plans and health insurance coverage to be designed and implemented on a timely basis, regulations must be published and available to the public well in advance of the effective

date of the requirements of the Affordable Care Act. It is not possible to have a full notice and comment process and to publish final regulations in the brief time between enactment of the Affordable Care Act and the date regulations are needed.

The Secretaries further find that issuance of proposed regulations would not be sufficient because the provisions of the Affordable Care Act protect significant rights of plan participants and beneficiaries and individuals covered by individual health insurance policies and it is essential that participants, beneficiaries, insureds, plan sponsors, and issuers have certainty about their rights and responsibilities. Proposed regulations are not binding and cannot provide the necessary certainty. By contrast, the interim final regulations provide the public with an opportunity for comment, but without delaying the effective date of the regulations.

For the foregoing reasons, the Departments have determined that it is impracticable and contrary to the public interest to engage in full notice and comment rulemaking before putting these interim final regulations into effect, and that it is in the public interest to promulgate interim final regulations.

IV. Economic Impact

Under Executive Order 12866 (58 FR 51735), a ``significant'' regulatory action is subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order defines a ``significant regulatory action'' as an action that is likely to result in a rule (1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ``economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. OMB has determined that this regulation is economically significant within the meaning of section 3(f)(1) of the Executive Order, because it is likely to have an annual effect on the economy of \$100 million in any one year. Accordingly, OMB has reviewed these rules pursuant to the Executive Order. The Departments provide an assessment of the potential costs, benefits, and transfers associated with these interim final regulations, summarized in the following table.

TABLE 1--Accounting Table (2011-2013)

Benefits:

Qualitative: By expanding coverage and eliminating cost sharing for the recommended preventive services, the Departments expect access and utilization of these services to increase. To the extent that individuals increase their use of these services the Departments anticipate several benefits: (1) prevention and reduction in transmission of illnesses as a result of immunization and screening of transmissible diseases; (2) delayed onset, earlier treatment, and reduction in morbidity and mortality as a result of early detection, screening, and counseling; (3) increased productivity and fewer sick days; and (4) savings from lower health care costs. Another benefit of these interim final regulations will be to distribute the cost of preventive services more equitably across the broad insured population.

Costs:

Qualitative: New costs to the health care system result when beneficiaries increase their use of preventive services in response to the changes in coverage and cost-sharing requirements of preventive services. The magnitude of this effect on utilization depends on the price elasticity of demand and the percentage change in prices facing those with reduced cost sharing or newly gaining coverage.

Transfers:

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Qualitative: Transfers will occur to the extent that costs that were previously paid out-of-pocket for certain preventive services will now be covered by group health plans and issuers under these interim final regulations. Risk pooling in the group market will result in sharing expected cost increases across an entire plan or employee group as higher average premiums for all enrollees. However, not all of those covered will utilize preventive services to an equivalent extent. As a result, these interim final regulations create a small transfer from those paying premiums in the group market utilizing less than the average volume of preventive services in their risk pool to those whose utilization is greater than average. To the extent there is risk pooling in the individual market, a similar transfer will occur.

A. The Need for Federal Regulatory Action

As discussed later in this preamble, there is current underutilization of preventive services, which stems from three main factors. First, due to turnover in the health insurance market, health insurance issuers do not currently have incentives to cover preventive services, whose benefits may only be realized in the future when an individual may no longer be enrolled. Second, many preventive services generate benefits that do not accrue immediately to the individual that receives the services, making the individual less likely to take-up, especially in the face of direct, immediate costs. Third, some of the benefits of preventive services accrue to society as a whole, and thus do not get factored into an individual's decision-making over whether

to obtain such services.

These interim final regulations address these market failures through two avenues. First, they require coverage of recommended preventive services by non-grandfathered group health plans and health insurance issuers in the group and individual markets, thereby overcoming plans' lack of incentive to invest in these services. Second, they eliminate cost-sharing requirements, thereby removing a barrier that could otherwise lead an individual to not obtain such services, given the long-term and partially external nature of benefits.

These interim final regulations are necessary in order to provide rules that plan sponsors and issuers can use to determine how to provide coverage for certain preventive health care services without the imposition of cost sharing in connection with these services.

B. PHS Act Section 2713, Coverage of Preventive Health Services (26 CFR 54.9815-2713T, 29 CFR 2590.715-2713, 45 CFR 147.130)

1. Summary

As discussed earlier in this preamble, PHS Act section 2713, as added by the Affordable Care Act, and these interim final regulations require a group health plan and a health insurance issuer offering group or individual health insurance coverage to provide benefits for and prohibit the imposition of cost-sharing requirements with respect to the following preventive health services:

Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force). While these guidelines will change over time, for the purposes of this impact analysis, the Departments utilized currently available guidelines, which include blood pressure and cholesterol screening, diabetes screening for hypertensive patients, various cancer and sexually transmitted infection screenings, and counseling related to aspirin use, tobacco cessation, obesity, and other topics.

Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved.

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 (HRSA).

With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force). The Department of HHS is developing these guidelines and expects to issue them no later than August 1, 2011.

2. Preventive Services

For the purposes of this analysis, the Departments used the relevant recommendations of the Task Force and Advisory Committee and current HRSA guidelines as described in section V later in this preamble. In addition to covering immunizations, these lists include such services as blood pressure and cholesterol screening, diabetes screening for hypertensive patients, various cancer and sexually transmitted infection screenings, genetic testing for the BRCA gene, adolescent depression screening, lead testing, autism testing, and oral health screening and counseling related to aspirin use, tobacco cessation, and obesity.

3. Estimated Number of Affected Entities

For purposes of the new requirements in the Affordable Care Act that apply to group health plans and health insurance issuers in the group and individual markets, the Departments have defined a large group health plan as an employer plan with 100 or more workers and a small group plan as an employer plan with less than 100 workers. The Departments estimated that there are approximately 72,000 large and 2.8 million small ERISA-covered group health plans with an estimated 97.0 million participants in large group plans and 40.9 million participants in small group plans.\6\ The Departments estimate that there are 126,000 governmental plans with 36.1 million participants in large plans and 2.3 million participants in small plans.\7\ The Departments estimate there are 16.7 million individuals under age 65 covered by individual health insurance policies.\8\

\6\ All participant counts and the estimates of individual policies are from the U.S. Department of Labor, EBSA calculations using the March 2008 Current Population Survey Annual Social and Economic Supplement and the 2008 Medical Expenditure Panel Survey.

\7\ Estimate is from the 2007 Census of Government.

\8\ US Census Bureau, Current Population Survey, March 2009.

As described in the Departments' interim final regulations relating to status as a grandfathered health plan,\9\ the Affordable Care Act preserves the ability of individuals to retain coverage under a group health plan or health insurance coverage in which the individual was enrolled on March 23, 2010 (a grandfathered health plan). Group health plans, and group and individual health insurance coverage, that are grandfathered health plans do not have to meet the requirements of these interim final regulations. Therefore, only plans and issuers

offering group and individual health insurance coverage that are not grandfathered health plans will be affected by these interim final regulations.

\9\ 75 FR 34538 (June 17, 2010).

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Plans can choose to relinquish their grandfather status in order to make certain otherwise permissible changes to their plans.\10\ The Affordable Care Act provides plans with the ability to maintain grandfathered status in order to promote stability for consumers while allowing plans and sponsors to make reasonable adjustments to lower costs and encourage the efficient use of services. Based on an analysis of the changes plans have made over the past few years, the Departments expect that more plans will choose to make these changes over time and therefore the number of grandfathered health plans is expected to decrease. Correspondingly, the number of plans and policies affected by these interim final regulations is likely to increase over time. In addition, the number of individuals receiving the benefits of the Affordable Care Act is likely to increase over time. The Departments' mid-range estimate is that 18 percent of large employer plans and 30 percent of small employer plans would relinquish grandfather status in 2011, increasing over time to 45 percent and 66 percent respectively by 2013, although there is substantial uncertainty surrounding these estimates.\11\

\10\ See 75 FR 34538 (June 17, 2010).

\11\ See 75 FR 34538 (June 17, 2010) for a detailed description of the derivation of the estimates for the percentages of grandfathered health plans. In brief, the Departments used data from the 2008 and 2009 Kaiser Family Foundations/Health Research and Educational Trust survey of employers to estimate the proportion of plans that made changes in cost-sharing requirements that would have caused them to relinquish grandfather status if those same changes were made in 2011, and then applied a set of assumptions about how employer behavior might change in response to the incentives created by the grandfather regulations to estimate the proportion of plans likely to relinquish grandfather status. The estimates of changes in 2012 and 2013 were calculated by using the 2011 calculations and assuming that an identical percentage of plan sponsors will relinquish grandfather status in each year.

Using the mid-range assumptions, the Departments estimate that in 2011, roughly 31 million people will be enrolled in group health plans subject to the prevention provisions in these interim final regulations, growing to approximately 78 million in 2013.\12\ The mid-range estimates suggest that approximately 98 million individuals will be enrolled in grandfathered group health plans in 2013, many of which already cover preventive services (see discussion of the extent of preventive services coverage in employer-sponsored plans later in this preamble).

\12\ To estimate the number of individuals covered in grandfathered health plans, the Departments extended the analysis described in 75 FR 34538, and estimated a weighted average of the number of employees in grandfathered health plans in the large employer and small employer markets separately, weighting by the number of employees in each employer's plan. Estimates for the large employer and small employer markets were then combined, using the estimates supplied above that there are 133.1 million covered lives in the large group market, and 43.2 million in the small group market.

In the individual market, one study estimated that 40 percent to 67 percent of individual policies terminate each year. Because all newly purchased individual policies are not grandfathered, the Departments expect that a large proportion of individual policies will not be grandfathered, covering up to and perhaps exceeding 10 million individuals.\13\

\13\ Adele M. Kirk. The Individual Insurance Market: A Building Block for Health Care Reform? Health Care Financing Organization Research Synthesis. May 2008.

However, not all of the individuals potentially affected by these interim final regulations will directly benefit given the prevalence and variation in insurance coverage today. State laws will affect the number of entities affected by all or some provision of these interim final regulations, since plans, policies, and enrollees in States that already have certain requirements will be affected to different degrees.\14\ For instance, 29 States require that health insurance

issuers cover most or all recommended immunizations for children.\15\ Of these 29 States, 18 States require first-dollar coverage of immunizations so that the insurers pay for immunizations without a deductible and 12 States exempt immunizations from copayments (e.g., \$5, \$10, or \$20 per vaccine) or coinsurance (e.g., 10 percent or 20 percent of charges). State laws also require coverage of certain other preventive health services. Every State except Utah mandates coverage for some type of breast cancer screening for women. Twenty-eight States mandate coverage for some cervical cancer screening and 13 States mandate coverage for osteoporosis screening.\16\

\14\ Of note, State insurance requirements do not apply to self-insured group health plans, whose participants and beneficiaries make up 57 percent of covered employees (in firms with 3 or more employees) in 2009 according to a major annual survey of employers due to ERISA preemption of State insurance laws. See e.g., Kaiser Family Foundation and Health Research and Education Trust, Employer Health Benefits 2009 Annual Survey (2009).

\15\ See e.g., American Academy of Pediatrics, State Legislative Report (2009).

\16\ See Kaiser Family Foundation, www.statehealthfacts.org.

Estimation of the number of entities immediately affected by some or all provisions of these interim final regulations is further complicated by the fact that, although not all States require insurance coverage for certain preventive services, many health plans have already chosen to cover these services. For example, most health plans cover most childhood and some adult immunizations contained in the recommendations from the Advisory Committee. A survey of small, medium and large employers showed that 78 percent to 80 percent of their point of service, preferred provider organization (PPO), and health maintenance organization (HMO) health plans covered childhood immunizations and 57 percent to 66 percent covered influenza vaccines in 2001.\17\ All 61 health plans (HMOs and PPOs) responding to a 2005 America's Health Insurance Plans (AHIP) survey covered childhood immunizations \18\ in their best-selling products and almost all health plans (60 out of 61) covered diphtheria-tetanus-pertussis vaccines and influenza vaccines for adults.\19\ A survey of private and public employer health plans found that 84 percent covered influenza vaccines in 2002-2003.\20\

\17\ See e.g., Mary Ann Bondi et. al., "Employer Coverage of Clinical Preventive Services in the United States," American Journal of Health Promotion, 20(3), pp. 214-222 (2006).

\18\ The specific immunizations include: DTaP (diphtheria and tetanus toxoids and acellular Pertussis), Hib (Haemophilus influenzae type b), Hepatitis B, inactivated polio, influenza, MMR (measles, mumps, and rubella), pneumococcal, and varicella vaccine.

\19\ McPhillips-Tangum C., Rehm B., Hilton O. "Immunization practices and policies: A survey of health insurance plans." AHIP Coverage. 47(1), 32-7 (2006).

\20\ See e.g., Matthew M. Davis et. al., "Benefits Coverage for Adult Vaccines in Employer-Sponsored Health Plans," University of Michigan for the CDC National Immunizations Program (2003).

Similarly, many health plans already cover preventive services today, but there are differences in the coverage of these services in the group and individual markets. According to a 2009 survey of employer health benefits, over 85 percent of employer-sponsored health insurance plans covered preventive services without having to meet a deductible.\21\ Coverage of preventive services does vary slightly by employer size, with large employers being more likely to cover such services than small employers.\22\ In contrast, coverage of preventive services is less prevalent and varies more significantly in the individual market.\23\ For PPOs,

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only 66.2 percent of single policies purchased covered adult physicals, while 94.1 percent covered cancer screenings.\24\

\21\ See e.g., Kaiser Family Foundation and Health Research and Education Trust, Employer Health Benefits 2009 Annual Survey (2009) available at <http://ehbs.kff.org/pdf/2009/7936.pdf>.

\22\ See e.g., Mary Ann Bondi et. al., "Employer Coverage of Clinical Preventive Services in the United States," American Journal of Health Promotion, 20(3), pp. 214-222 (2006).

\23\ See e.g., Matthew M. Davis et. al., "Benefits Coverage for Adult Vaccines in Employer-Sponsored Health Plans," University of Michigan for the CDC National Immunizations Program (2003).

\24\ See Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits. Available at http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf.

In summary, the number of affected entities depends on several factors, such as whether a health plan retains its grandfather status,

the number of new health plans, whether State benefit requirements for preventive services apply, and whether plans or issuers voluntarily offer coverage and/or no cost sharing for recommended preventive services. In addition, participants, beneficiaries, and enrollees in such plans or health insurance coverage will be affected in different ways: Some will newly gain coverage for recommended preventive services, while others will have the cost sharing that they now pay for such services eliminated. As such, there is considerable uncertainty surrounding estimation of the number of entities affected by these interim final regulations.

4. Benefits

The Departments anticipate that four types of benefits will result from these interim final regulations. First, individuals will experience improved health as a result of reduced transmission, prevention or delayed onset, and earlier treatment of disease. Second, healthier workers and children will be more productive with fewer missed days of work or school. Third, some of the recommended preventive services will result in savings due to lower health care costs. Fourth, the cost of preventive services will be distributed more equitably.

By expanding coverage and eliminating cost sharing for recommended preventive services, these interim final regulations could be expected to increase access to and utilization of these services, which are not used at optimal levels today. Nationwide, almost 38 percent of adult residents over 50 have never had a colorectal cancer screening (such as a sigmoidoscopy or a colonoscopy) \25\ and almost 18 percent of women over age 18 have not been screened for cervical cancer in the past three years.\26\ Vaccination rates for childhood vaccines are generally high due to State laws requiring certain vaccinations for children to enter school, but recommended childhood vaccines that are not subject to State laws and adult vaccines have lower vaccination rates (e.g., the meningococcal vaccination rate among teenagers is 42 percent).\27\ Studies have shown that improved coverage of preventive services leads to expanded utilization of these services,\28\ which would lead to substantial benefits as discussed further below.

\25\ This differs from the Task Force recommendation that individuals aged 50-75 receive fecal occult blood testing, sigmoidoscopy, or colonoscopy screening for colorectal cancer.

\26\ For Behavioral Risk Factor Surveillance System Numbers see e.g. Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, (2008) at <http://apps.nccd.cdc.gov/BRFSS/page.asp?cat=CC&yr=2008&state=UB#CC>.

\27\ See <http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis> for vaccination rates.

\28\ See e.g., Jonathan Gruber, The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond, Kaiser Family Foundation (Oct. 2006). This paper examines an experiment in which copays randomly vary across several thousand individuals. The author finds that individuals are sensitive to prices for health services--i.e. as copays decline, more services are demanded. See e.g., Sharon Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts At One Year," Health Affairs, Volume 27, Number 4 (June 2008). The author investigated the case of Massachusetts, where coverage of preventive services became a requirement in 2007, and found that for individuals under 300 percent of the poverty line, doctor visits for preventive care increased by 6.1 percentage points in the year after adoption, even after controlling for observable characteristics. Additionally, the incidence of individuals citing cost as the reason for not receiving preventive screenings declined by 2.8 percentage points from 2006 to 2007. In the Massachusetts case, these preventive care services were not necessarily free; therefore, economists would expect a higher differential under these interim final rules because of the price sensitivity of health care usage.

In addition, these interim final regulations limit preventive service coverage under this provision to services recommended by the Task Force, Advisory Committee, and HRSA. The preventive services given a grade of A or B by the Task Force have been determined by the Task Force to have at least fair or good \29\ evidence that the preventive service improves important health outcomes and that benefits outweigh harms in the judgment of an independent panel of private sector experts in primary care and prevention.\30\ Similarly, the mission of the Advisory Committee is to provide advice that will lead to a reduction in the incidence of vaccine preventable diseases in the United States, and an increase in the safe use of vaccines and related biological products. The comprehensive guidelines for infants, children, and adolescents supported by HRSA are developed by multidisciplinary professionals in the relevant fields to provide a framework for improving children's health and reducing morbidity and mortality based on a review of the relevant evidence. The statute and interim final regulations limit the preventive services covered to those recommended by the Task Force, Advisory Committee, and HRSA because the benefits of these preventive services will be higher than others that may be popular but unproven.

\29\ The Task Force defines good and fair evidence as follows.

Good: Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair: Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality or consistency of the individual studies, generalizability to routine practice or indirect nature of the evidence on health outcomes. See <http://www.ahrq.gov/clinic/uspstf/gradespre.htm#drec>.

\30\ See <http://www.ahrq.gov/clinic/uspstf/gradespre.htm#drec> for details of the Task Force grading.

Research suggests significant health benefits from a number of the preventive services that would be newly covered with no cost sharing by plans and issuers under the statute and these interim final regulations. A recent article in JAMA stated, "By one account, increasing delivery of just five clinical preventive services would avert 100,000 deaths per year." \31\ These five services are all items and services recommended by the Task Force, Advisory Committee, and/or the comprehensive guidelines supported by HRSA. The National Council on Prevention Priorities (NCCPP) estimated that almost 150,000 lives could potentially be saved by increasing the 2005 rate of utilization to 90 percent for eight of the preventive services recommended by the Task Force or Advisory Committee.\32\ Table 2 shows eight of the services and the number of lives potentially saved if utilization of preventive services were to increase to 90 percent.

\31\ Woolf, Steven. A Closer Look at the Economic Argument for Disease Prevention. JAMA 2009;301(5):536-538.

\32\ See National Commission on Prevention Priorities. Preventive Care: A National Profile on Use, Disparities, and Health Benefits. Partnership for Prevention, August 2007 at <http://www.prevent.org/content/view/full/129/72/#citations> accessed on 6/22/2010. Lives saved were estimated using models previously developed to rank clinical preventive services. See Maciosek MV, Edwards NM, Coffield AB, Flottemesch TJ, Nelson WW, Goodman MJ, Rickey DA, Butani AB, Solberg LI. Priorities among effective clinical preventive services: methods. Am J Prev Med 2006; 31(1):90-96.

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TABLE 2.--Lives Saved From Increasing Utilization of Selected Preventive Services to 90 Percent

Preventive service	Population group	Percent utilizing preventive service in 2005	Lives saved annually if percent utilizing preventive service increased to 90 percent
Regular aspirin use.....	Men 40+ and women 50+.....	40	45,000
Smoking cessation advice and help to quit.	All adult smokers.....	28	42,000
Colorectal cancer screening.....	Adults 50+.....	48	14,000
Influenza vaccination.....	Adults 50+.....	37	12,000
Cervical cancer screening in the past 3 years.	Women 18-64.....	83	620
Cholesterol screening.....	Men 35+ and women 45+.....	79	2,450
Breast cancer screening in the past 2 years.	Women 40+.....	67	3,700
Chlamydia screening.....	Women 16-25.....	40	30,000

Source: National Commission on Prevention Priorities, 2007.

Since financial barriers are not the only reason for sub-optimal utilization rates, population-wide utilization of preventive services is unlikely to increase to the 90 percent level assumed in Table 2 as a result of these interim final regulations. Current utilization of preventive services among insured populations varies widely, but the Departments expect that utilization will increase among those individuals in plans affected by the regulation because the provisions eliminate cost sharing and require coverage for these services.

These interim final regulations are expected to increase the take-up rate of preventive services and are likely, over time, to lead physicians to increase their use of these services knowing that they will be covered, and covered with zero copayment. In the absence of data on the elasticity of demand for these specific services, it is difficult to know precisely how many more patients will use these services. Evidence from studies comparing the utilization of preventive services such as blood pressure and cholesterol screening between insured and uninsured individuals with relatively high incomes suggests that coverage increases usage rates in a wide range between three and 30 percentage points, even among those likely to be able to afford basic preventive services out-of-pocket.\33\ A reasonable assumption is that the average increase in utilization of these services will be modest, perhaps on the order of 5 to 10 percentage points for some of them. For services that are generally covered without cost sharing in the current market, the Departments would expect minimal change in

utilization.

\33\ The Commonwealth Fund. ``Insurance Coverage and the Receipt of Preventive Care.'' 2005. <http://www.commonwealthfund.org/Content/Performance-Snapshots/Financial-and-Structural-Access-to-Care/Insurance-Coverac>

Preventive services' benefits have also been evaluated individually. Effective cancer screening, early treatment, and sustained risk reduction could reduce the death rate due to cancer by 29 percent.\34\ Improved blood sugar control could reduce the risk for eye disease, kidney disease and nerve disease by 40 percent in people with Type 1 or Type 2 diabetes.\35\

\34\ Curry, Susan J., Byers, Tim, and Hewitt, Maria, eds. 2003. Fulfilling the Potential of Cancer Prevention and Early Detection. Washington, DC: National Academies Press.

\35\ Centers for Disease Control and Prevention. 2010. Diabetes at a Glance. See http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2010/diabetes_aag.pdf.

Some recommended preventive services have both individual and public health value. Vaccines have reduced or eliminated serious diseases that, prior to vaccination, routinely caused serious illnesses or deaths. Maintaining high levels of immunization in the general population protects the un-immunized from exposure to the vaccine-preventable disease, so that individuals who cannot receive the vaccine or who do not have a sufficient immune response to the vaccine to protect against the disease are indirectly protected.\36\

\36\ See Modern Infectious Disease Epidemiology by Johan Giesecke 1994, Chapter 18, The Epidemiology of Vaccination.

A second type of benefit from these interim final regulations is improved workplace productivity and decreased absenteeism for school children. Numerous studies confirm that ill health compromises worker output and that health prevention efforts can improve worker productivity. For example, one study found that 69 million workers reported missing days due to illness and 55 million workers reported a time when they were unable to concentrate at work because of their own illness or a family member's illness.\37\ Together, labor time lost due to health reasons represents lost economic output totaling \$260 billion per year.\38\ Prevention efforts can help prevent these types of losses. Studies have also shown that reduced cost-sharing for medical services results in fewer restricted-activity days at work,\39\ and increased access to health insurance coverage improves labor market outcomes by improving worker health.\40\ Thus, the expansion of benefits and the elimination of cost sharing for preventive services as provided in these

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interim final regulations can be expected to have substantial productivity benefits in the labor market.

\37\ Health and Productivity Among U.S. Workers, Karen Davis, Ph.D., Sara R. Collins, Ph.D., Michelle M. Doty, Ph.D., Alice Ho, and Alyssa L. Holmgren, The Commonwealth Fund, August 2005 <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2005/Aug/Health-and-Pr>
 \38\ Ibid.

\39\ See e.g., RAND, The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate, Rand Research Brief, Number 9174 (2006), at http://www.rand.org/pubs/research_briefs/2006/RAND_RB9174.pdf and Janet Currie et al., ``Has Public Health Insurance for Older Children Reduced Disparities in Access to Care and Health Outcomes?'' Journal of Health Economics, Volume 27, Issue 6, pages 1567-1581 (Dec. 2008). With early childhood interventions, there appear to be improved health outcomes in later childhood. Analogously, health interventions in early adulthood could have benefits for future productivity.

\40\ In a RAND policy brief, the authors cite results from the RAND Health Insurance Experiment in which cost-sharing is found to correspond with workers having fewer restricted-activity days--evidence that free care for certain services may be productivity enhancing. See e.g., RAND, The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate, Rand Research Brief, Number 9174 (2006), at http://www.rand.org/pubs/research_briefs/2006/RAND_RB9174.pdf. See e.g. Janet Currie et. al., ``Has Public Health Insurance for Older Children Reduced Disparities in Access to Care and Health Outcomes?'' Journal of Health Economics, Volume 27, Issue 6, pages 1567-1581 (Dec. 2008). With early childhood interventions, there appears to be improved health outcomes in later childhood. Analogously, health interventions in early adulthood could have benefits for future productivity. Council of Economic Advisers. ``The Economic Case for Health Reform.'' (2009).

Illnesses also contribute to increased absenteeism among school children, which could be avoided with recommended preventive services.

In 2006, 56 percent of students missed between one and five days of school due to illness, 10 percent missed between six and ten days and five percent missed 11 or more days.\41\ Obesity in particular contributes to missed school days: One study from the University of Pennsylvania found that overweight children were absent on average 20 percent more than their normal-weight peers.\42\ Studies also show that influenza contributes to school absenteeism, and vaccination can reduce missed school days and indirectly improve community health.\43\ These interim final regulations will ensure that children have access to preventive services, thus decreasing the number of days missed due to illness.\44\ Similarly, regular pediatric care, including care by physicians specializing in pediatrics, can improve child health outcomes and avert preventable health care costs. For example, one study of Medicaid enrolled children found that when children were up to date for their age on their schedule of well-child visits, they were less likely to have an avoidable hospitalization at a later time.\45\

\41\ Bloom B, Cohen RA. Summary health statistics for U.S. children: National Health Interview Survey, 2006. Vital Health Stat 2007;10(234). Available at <http://www.cdc.gov/nchs/nhis.htm>.

\42\ University of Pennsylvania 2007: <http://www.upenn.edu/pennnews/news/childhood-obesity-indicates-greater-risk-school-absenteeism-university>

\43\ Davis, Mollie M., James C. King, Ginny Cummings, and Laurence S. Madger. "Countywide School-Based Influenza Immunization: Direct and Indirect Impact on Student Absenteeism." Pediatrics 122.1 (2008).

\44\ Moonie, Sheniz, David A. Sterling, Larry Figgs, and Mario Castro. "Asthma Status and Severity Affects Missed School Days." Journal of School Health 76.1 (2006): 18-24.

\45\ Bye, "Effectiveness of Compliance with Pediatric Preventative Care Guidelines Among Medicaid Beneficiaries."

A third type of benefit from some preventive services is cost savings. Increasing the provision of preventive services is expected to reduce the incidence or severity of illness, and, as a result, reduce expenditures on treatment of illness. For example, childhood vaccinations have generally been found to reduce such expenditures by more than the cost of the vaccinations themselves and generate considerable benefits to society. Researchers at the Centers for Disease Control and Prevention (CDC) studying the economic impact of DTaP (diphtheria and tetanus toxoids and acellular Pertussis), Td (tetanus and diphtheria toxoids), Hib (Haemophilus influenzae type b), IPV (inactivated poliovirus), MMR (measles, mumps and rubella), Hepatitis B and varicella routine childhood vaccines found that every dollar spent on immunizations in 2001 was estimated to save \$5.30 on direct health care costs and \$16.50 on total societal costs of the diseases as they are prevented or reduced (direct health care associated with the diseases averted were \$12.1 billion and total societal costs averted were \$33.9 billion).\46\

\46\ Fangjun Zhou, Jeanne Santoli, Mark L. Messonnier, Hussain R. Yusuf, Abigail Shefer, Susan Y. Chu, Lance Rodewald, Rafael Harpaz. Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the United States. Archives of Pediatric and Adolescent Medicine 2005; 159(12): 1136-1144. The estimates of the cost savings are based on current immunization levels. The incremental impact of increasing immunization rates is likely to be smaller, but still significant and positive.

A review of preventive services by the National Committee on Prevention Priorities found that, in addition to childhood immunizations, two of the recommended preventive services--discussing aspirin use with high-risk adults and tobacco use screening and brief intervention--are cost-saving on net.\47\ By itself, tobacco use screening with a brief intervention was found to save more than \$500 per smoker.\48\

\47\ Maciosek MV, Coffield AB, Edwards NM, Coffield AB, Flottemesch TJ, Goodman MJ, Solberg LI. Priorities among effective clinical preventive services: Results of a Systematic Review and Analysis. Am J Prev Med 2006; 31(1):52-61.

\48\ Solberg LI, Maciosek, MV, Edwards NM, Khanchandani HS, and Goodman MJ. Repeated tobacco-use screening and intervention in clinical practice: Health impact and cost effectiveness. American Journal of Preventive Medicine. 2006;31(1).

Another area where prevention could achieve savings is obesity prevention and reduction. Obesity is widely recognized as an important driver of higher health care expenditures.\49\ The Task Force recommends children over age six and adults be screened for obesity and be offered or referred to counseling to improve weight status or promote weight loss. Increasing obesity screening and referrals to counseling should decrease obesity and its related costs. If providers are able to proactively identify and monitor obesity in child patients, they may reduce the incidence of adult health conditions that can be expensive to treat, such as diabetes, hypertension, and adult

obesity.\50\ One recent study estimated that a one-percentage-point reduction in obesity among twelve-year-olds would save \$260.4 million in total medical expenditures.\51\

\49\ Congressional Budget Office. ``Technological Change and the Growth of Health Care Spending.'' January 2008. Box 1, pdf p. 18. <http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf>.

\50\ ``Working Group Report on Future Research Directions in Childhood Obesity Prevention and Treatment.'' National Heart, Lung and Blood Institute, National Institutes of Health, U.S. Department of Health and Human Services (2007), available at <http://www.nhlbi.nih.gov/meetings/workshops/child-obesity/index.htm>.

\51\ Ibid.

A full quantification of the cost savings from the extension of coverage of preventive services in these interim final regulations is not possible, but to illustrate the potential savings, an assessment of savings from obesity reduction was conducted. According to the CDC, in 2008, 34.2 percent of U.S. adults and 16.9 percent of children were obese (defined as having a body mass index (BMI) of 30.0 or greater).\52\ Obesity is associated with increased risk for coronary heart disease, hypertension, stroke, type 2 diabetes, several types of cancer, diminished mobility, and social stigmatization.\53\ As a result, obesity is widely recognized as an important driver of higher health care expenditures on an individual \54\ and national level.\55\

\52\ Centers for Disease Control and Prevention. ``Obesity and Overweight.'' 2010. <http://www.cdc.gov/nchs/fastats/overwt.htm>.

\53\ Agency for Healthcare Research and Quality (AHRQ). ``Screening for Obesity in Adults.'' December 2003. <http://www.ahrq.gov/clinic/3rduspstf/obesity/obesrr.pdf>.

\54\ Thorpe, Kenneth E. ``The Future Costs of Obesity: National and State Estimates of the Impact of Obesity on Direct Health Care Expenses.'' November 2009; McKinsey Global Institute. ``Sample data suggest that obese adults can incur nearly twice the annual health care costs of normal-weight adults.'' 2007.

\55\ Congressional Budget Office. ``Technological Change and the Growth of Health Care Spending.'' January 2008. Box 1, pdf p. 18. <http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf>.

As described below, the Departments' analysis assumes that the utilization of preventive services will increase when they are covered with zero copayment, and these interim final regulations are expected to increase utilization of dietary counseling services both among people who currently have the service covered with a copayment and among people for whom the service is not currently covered at all.

Data from the 2009 Kaiser Family Foundation Employer Health Benefits Survey shows that 73 percent of employees with employer-sponsored insurance from a small (< 200 employees) employer do not currently have coverage for weight loss programs,

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compared to 38 percent at large firms.\56\ In the illustrative analysis below, the share of individuals without weight loss coverage in the individual market is assumed to be equal to the share in the small group market.

\56\ Kaiser Family Foundation. 2009 Employer Health Benefits Annual Survey. Public Use File provided to CEA; documentation of statistical analysis available upon request. See <http://ehbs.kff.org>.

The size of the increase in the number of individuals receiving dietary counseling or other weight loss services will be limited by current physician practice patterns, in which relatively few individuals who are obese receive physician recommendations for dietary counseling. In one study of patients at an internal medicine clinic in the Bronx, NY, approximately 15 percent of obese patients received a recommendation for dietary counseling.\57\ Similarly, among overweight and obese patients enrolled in the Cholesterol Education and Research Trial, approximately 15 to 20 percent were referred to nutrition counseling.\58\

\57\ Davis NJ, Emerenini A, Wylie-Rosett J. ``Obesity management: physician practice patterns and patient preference,'' Diabetes Education. 2006 Jul-Aug; 32(4):557-61.

\58\ Molly E. Waring, PhD, Mary B. Roberts, MS, Donna R. Parker, ScD and Charles B. Eaton, MD, MS. ``Documentation and Management of Overweight and Obesity in Primary Care,'' The Journal of the American Board of Family Medicine 22 (5): 544-552 (2009).

These interim final regulations are expected to increase the take-up rate of counseling among patients who are referred to it, and may, over time, lead physicians to increase their referral to such counseling, knowing that it will be covered, and covered without cost

sharing. The effect of these interim final regulations is expected to be magnified because of the many other public and private sector initiatives dedicated to combating the obesity epidemic.

In the absence of data on take-up of counseling among patients who are referred by their physicians, it is difficult to know what fraction of the estimated 15 percent to 20 percent of patients who are currently referred to counseling follow through on that referral, or how that fraction will change after coverage of these services is expanded. A reasonable assumption is that utilization of dietary counseling among patients who are obese might increase by five to 10 percentage points as a result of these interim final regulations. If physicians change their behavior and increase the rate at which they refer to counseling, the effect might be substantially larger.

The share of obese individuals without weight loss coverage is estimated to be 29 percent.⁵⁹ It is assumed that obese individuals have health care costs 39 percent above average, based on a McKinsey Global Institute analysis.⁶⁰ The Task Force noted that counseling interventions led to sustained weight loss ranging from four percent to eight percent of body weight, although there is substantial heterogeneity in results across interventions, with many interventions having little long-term effect.⁶¹ Assuming midpoint reduction of six percent of body weight, the BMI for an individual taking up such an intervention would fall by six percent as well, as height would remain constant. Based on the aforementioned McKinsey Global Institute analysis, a six percent reduction in BMI for an obese individual (from 32 to around 30, for example) would result in a reduction in health care costs of approximately five percent. This parameter for cost reduction is subject to considerable uncertainty, given the wide range of potential weight loss strategies with varying degrees of impact on BMI, and their interconnectedness with changes in individual health care costs.

⁵⁹ This estimate is constructed using a weighted average obesity rate taking into account the share of the population aged 0 to 19 and 20 to 74 and their respective obesity rates, derived from Census Bureau and Centers for Disease Control and Prevention data. U.S. Census Bureau. "Current Population Survey (CPS) Table Creator." 2010. http://www.census.gov/hhes/www/cpstc/cps_table_creator.html. Centers for Disease Control and Prevention. "Obesity and Overweight." 2010. <http://www.cdc.gov/nchs/fastats/overwt.htm>.
⁶⁰ McKinsey Global Institute Analysis provided to CEA.
⁶¹ Agency for Healthcare Research and Quality (AHRQ). "Screening for Obesity in Adults." December 2003. p. 4. <http://www.ahrq.gov/clinic/3rduspstf/obesity/obesrr.pdf>.

Multiplying the percentage reduction in health care costs by the total premiums of obese individuals newly gaining obesity prevention coverage allows for an illustrative calculation of the total dollar reduction in premiums, and dividing by total premiums for the affected population allows for an estimate of the reduction in average premiums across the entire affected population. Doing so results in a potential private premium reduction of 0.05 percent to 0.1 percent from lower health care costs due to a reduction in obesity for enrollees in non-grandfathered plans. This does not account for potential savings in Medicaid, Medicare, or other health programs.

A fourth benefit of these interim final regulations will be to distribute the cost of preventive services more equitably across the broad insured population. Some Americans in plans affected by these regulations currently have no coverage of certain recommended preventive services, and pay for them entirely out-of-pocket. For some individuals who currently have no coverage of certain recommended preventive services, these interim final regulations will result in a large savings in out-of-pocket payments, and only a small increase in premiums. Many other Americans have limited coverage of certain recommended preventive services, with large coinsurance or deductibles, and also make substantial out-of-pocket payments to obtain preventive services. Some with limited coverage of preventive services will also experience large savings as a result of these interim final regulations. Reductions in out-of-pocket costs are expected to be largest among people in age groups in which relatively expensive preventive services are most likely to be recommended.

5. Costs and Transfers

The changes in how plans and issuers cover the recommended preventive services resulting from these interim final regulations will result in changes in covered benefits and premiums for individuals in plans and health insurance coverage subject to these interim final regulations. New costs to the health system result when beneficiaries increase their use of preventive services in response to the changes in coverage of preventive services. Cost sharing, including coinsurance, deductibles, and copayments, divides the costs of health services between the insurer and the beneficiaries. The removal of cost sharing increases the quantity of services demanded by lowering the direct cost of the service to consumers. Therefore, the Departments expect that the statute and these interim final regulations will increase utilization of the covered preventive services. The magnitude of this effect on utilization depends on the price elasticity of demand.

Several studies have found that individuals are sensitive to prices for health services.⁶² Evidence that consumers change their utilization of preventive services is available from CDC researchers who studied out-of-pocket costs of immunizations for

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privately insured children up to age 5 in families in Georgia in 2003, to find that a one percent increase in out-of-pocket costs for routine immunizations (DTaP, IPV, MMR, Hib, and Hep B) was associated with a 0.07 percent decrease in utilization.\63\

\62\ See e.g., Jonathan Gruber, *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond*, Kaiser Family Foundation (Oct. 2006). This paper examines an experiment in which copays randomly vary across several thousand individuals. The author finds that individuals are sensitive to prices for health services--i.e., as copays decline, more services are demanded.

\63\ See e.g., Noelle-Angelique Molinari et al., "Out-of-Pocket Costs of Childhood Immunizations: A Comparison by Type of Insurance Plan," *Pediatrics*, 120(5) pp. 148-156 (2006).

Along with new costs of induced utilization, there are transfers associated with these interim final regulations. A transfer is a change in who pays for the services, where there is not an actual change in the level of resources used. For example, costs that were previously paid out-of-pocket for certain preventive services will now be covered by plans and issuers under these interim final regulations. Such a transfer of costs could be expected to lead to an increase in premiums.

a. Estimate of Average Changes in Health Insurance Premiums

The Departments assessed the impact of eliminating cost sharing, increases in services covered, and induced utilization on the average insurance premium using a model to evaluate private health insurance plans against a nationally representative population. The model is based on the Medical Expenditure Panel Survey data from 2004, 2005, and 2006 on household spending on health care, which are scaled to levels consistent with the CMS projections of the National Health Expenditure Accounts.\64\ This data is combined with data from the Employer Health Benefits Surveys conducted by the Kaiser Family Foundation and Health Research and Education Trust to model a "typical PPO coverage" plan. The model then allows the user to assess changes in covered expenses, benefits, premiums, and induced utilization of services resulting from changes in the characteristics of the plan. The analysis of changes in coverage is based on the average per-person covered expenses and insurance benefits. The average covered expense is the total charge for covered services; insurance benefits are the part of the covered expenses covered by the insurer. The effect on the average premium is then estimated based on the percentage changes in the insurance benefits and the distribution of the individuals across individual and group markets in non-grandfathered plans. The Departments assume that the percent increase for insurance benefits and premiums will be the same. This is based on two assumptions: (1) That administrative costs included in the premium will increase proportionally with the increase in insurance benefits; and (2) that the increases in insurance benefits will be directly passed on to the consumer in the form of higher premiums. These assumptions bias the estimates of premium changes upward. Using this model, the Departments assessed: (1) Changes in cost-sharing for currently covered and utilized services, (2) changes in services covered, and (3) induced utilization of preventive services. There are several additional sources of uncertainty concerning these estimates. First, there is no accurate, granular data on exactly what baseline coverage is for the particular preventive services addressed in these interim final regulations. Second, there is uncertainty over behavioral assumptions related to additional utilization that results from reduced cost-sharing. Therefore, after providing initial estimates, the Departments provide a sensitivity analysis to capture the potential range of impacts of these interim final regulations.

\64\ The National Health Expenditure Accounts (NHEA) are the official estimates of total health care spending in the United States. See http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp.

From the Departments' analysis of the Medical Expenditure Panel Survey (MEPS) data, controlled to be consistent with projections of the National Health Expenditure Accounts, the average person with employer-sponsored insurance (ESI) has \$264 in covered expenses for preventive services, of which \$240 is paid by insurance, and \$24 is paid out-of-pocket.\65\ When preventive services are covered with zero copayment, the Departments expect the average preventive benefit (holding utilization constant) will increase by \$24. This is a 0.6 percent increase in insurance benefits and premiums for plans that have relinquished their grandfather status. A similar, but larger effect is expected in the individual market because existing evidence suggests that individual health insurance policies generally have less generous benefits for preventive services than group health plans. However, the evidence base for current coverage and cost sharing for preventive services in individual health insurance policies is weaker than for group health plans, making estimation of the increase in average benefits and premiums in the individual market highly uncertain.

\65\ The model does not distinguish between recommended and non-recommended preventive services, and so this likely represents an overestimate of the insurance benefits for preventive services.

For analyses of changes in covered services, the Departments used the Blue Cross/Blue Shield Standard (BC/BS) plan offered through the Federal Employees Health Benefits Program as an average plan.\66\ Other analyses have used the BC/BS standard option as an average plan as it was designed to reflect standard practice within employer-sponsored health insurance plans.\67\ BC/BS covers most of the preventive services listed in the Task Force and Advisory Committee recommendations, and most of the preventive services listed in the comprehensive guidelines for infants, children, and adolescents supported by HRSA. Not covered by the BC/BS Standard plan are the recommendations for genetic testing for the BRCA gene, adolescent depression screening,\68\ lead testing, autism testing, and oral health screening.\69\

\66\ The Blue Cross Blue Shield standard option plan documentation is available online at <http://fepblue.org/benefitplans/standard-option/index.html>.

\67\ Frey A, Mika S, Nuzum R, and Schoen C. "Setting a National Minimum Standard for Health Benefits: How do State Benefit Mandates Compare with Benefits in Large-Group Plans?" Issue Brief.

Commonwealth Fund June 2009 available at <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/Jun/Setting-a-National-Minimum-Standard-for-Health-Benefits-How-do-State-Benefit-Mandates-Compare-with-Benefits-in-Large-Group-Plans?>

\68\ The Task Force recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing and screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.

\69\ Lead, autism, and oral health screening are from the HRSA comprehensive guidelines.

The Departments estimated the increase in benefits from newly covered services by estimating the number of new services that would be provided times the cost of providing the services, and then spread these new costs across the total insured population. The Departments estimated that adding coverage for genetic screening and depression screening would increase insurance benefits an estimated 0.10 percent. Adding lead testing, autism testing, and oral health screening would increase insurance benefits by an estimated 0.02 percent. This results in a total average increase in insurance benefits on these services of 0.12 percent, or just over \$4 per insured person. This increase represents a mixture of new costs and transfers, dependent on whether beneficiaries previously would have purchased these services on their own. It is also important to remember that actual plan

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impacts will vary depending on baseline benefit levels, and that grandfathered health plans will not experience any impact from these interim final regulations. The Departments expect the increase to be larger in the individual market because coverage of preventive services in the individual market is less complete than coverage in the group market, but as noted previously, the evidence base for the individual market is weaker than that of the group market, making detailed estimates of the size of this effect difficult and highly uncertain.

Actuaries use an "induction formula" to estimate the behavioral change in response to changes in the relative levels of coverage for health services. For this analysis, the Departments used the model to estimate the induced demand (the increased use of preventive services). The model uses a standard actuarial formula for induction $1/(1+\alpha \cdot P)$, where α is the "induction parameter" and P is the average fraction of the cost of services paid by the consumer. The induction parameter for physician services is 0.7, derived by the standard actuarial formula that is generally consistent with the estimates of price elasticity of demand from the RAND Health Insurance Experiment and other economic studies.\70\ Removing cost sharing for preventive services lowers the direct cost to consumers of using preventive services, which induces additional utilization, estimated with the model above to increase covered expenses and benefits by approximately \$17, or 0.44 percent in insurance benefits in group health plans. The Departments expect a similar but larger effect in the individual market, although these estimates are highly uncertain.

\70\ Standard formula best described in "Quantity-Price Relationships in Health Insurance", Charles L Trowbridge, Chief Actuary, Social Security Administration (DHEW Publication No. (SSA)73-11507, November 1972).

The Departments calculated an estimate of the average impact using the information from the analyses described above, using estimates of the number of individuals in non-grandfathered health plans in the group and individual markets in 2011. The Departments estimate that

premiums will increase by approximately 1.5 percent on average for enrollees in non-grandfathered plans. This estimate assumes that any changes in insurance benefits will be directly passed on to the consumer in the form of changes in premiums. As mentioned earlier, this assumption biases the estimates of premium change upward.

b. Sensitivity analysis

As discussed previously, there is substantial uncertainty associated with the estimates presented above. To address the uncertainty in the group market, the Departments first varied the estimated change to underlying benefits, to address the particular uncertainty behind the estimate of baseline coverage of preventive services in the group market. The estimate for the per person annual increase in insurance benefits from adding coverage for new services is approximately \$4. The Departments considered the impact of a smaller and larger addition in benefits of approximately \$2 and \$6 per person. To consider the impact of uncertainty around the size of the behavioral change (that is, the utilization of more services when cost sharing is eliminated), the Departments analyzed the impact on insurance benefits if the behavioral change were 15 percent smaller and 15 percent larger.

In the individual market, to accommodate the greater uncertainty relative to the group market, the Departments considered the impact of varying the increase in benefits resulting from cost shifting due to the elimination of cost sharing, in addition to varying the cost of newly covered services and behavioral change.

Combining results in the group and individual markets for enrollees in non-grandfathered plans, the Departments' low-end is a few tenths of a percent lower than the mid-range estimate of approximately 1.5 percent, and the high-end estimate is a few tenths of a percent higher. Grandfathered health plans are not subject to these interim final regulations and therefore would not experience this premium change.

6. Alternatives Considered

Several provisions in these interim final regulations involved policy choices. One was whether to allow a plan or issuer to impose cost sharing for an office visit when a recommended preventive service is provided in that visit. Sometimes a recommended preventive service is billed separately from the office visit; sometimes it is not. The Departments decided that the cost sharing prohibition of these interim final regulations applies to the specific preventive service as recommended by the guidelines. Therefore, if the preventive service is billed separately from the office visit, it is the preventive service that has cost sharing waived, not the entire office visit.

A second policy choice was if the preventive service is not billed separately from the office visit, whether these interim final regulations should prohibit cost sharing for any office visit in which any recommended preventive service was administered, or whether cost sharing should be prohibited only when the preventive service is the primary purpose of the office visit. Prohibiting cost sharing for office visits when any recommended preventive service is provided, regardless of the primary purpose of the visit, could lead to an overly broad application of these interim final regulations; for example, a person who sees a specialist for a particular condition could end up with a zero copayment simply because his or her blood pressure was taken as part of the office visit. This could create financial incentives for consumers to request preventive services at office visits that are intended for other purposes in order to avoid copayments and deductibles. The increased prevalence of the application of zero cost sharing would lead to increased premiums compared with the chosen option, without a meaningful additional gain in access to preventive services.

A third issue involves health plans that have differential cost sharing for services provided by providers who are in and out of their networks. These interim final regulations provide that a plan or issuer is not required to provide coverage for recommended preventive services delivered by an out-of-network provider. The plan or issuer may also impose cost sharing for recommended preventive services delivered by an out-of-network provider. The Departments considered that requiring coverage by out-of-network providers at no cost sharing would result in higher premiums for these interim final regulations. Plans and issuers negotiate allowed charges with in-network providers as a way to promote effective, efficient health care, and allowing differences in cost sharing in- and out-of-network enables plans to encourage use of in-network providers. Allowing zero cost sharing for out of network providers could reduce providers' incentives to participate in insurer networks. The Departments decided that permitting cost sharing for recommended preventive services provided by out-of-network providers is the appropriate option to preserve choice of providers for individuals, while avoiding potentially larger increases in costs and transfers as well as potentially lower quality care.

C. Regulatory Flexibility Act--Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes

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certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the APA (5 U.S.C. 551 et seq.) and that are likely to have a significant economic impact on a substantial number of small entities. Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act authorize

the Secretaries to promulgate any interim final rules that they determine are appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B or title I of ERISA, and part A of title XXVII of the PHS Act, which include PHS Act sections 2701 through 2728 and the incorporation of those sections into ERISA section 715 and Code section 9815.

Moreover, under Section 553(b) of the APA, a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. These interim final regulations are exempt from APA, because the Departments made a good cause finding that a general notice of proposed rulemaking is not necessary earlier in this preamble. Therefore, the RFA does not apply and the Departments are not required to either certify that the rule would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analysis.

Nevertheless, the Departments carefully considered the likely impact of the rule on small entities in connection with their assessment under Executive Order 12866. Consistent with the policy of the RFA, the Departments encourage the public to submit comments that suggest alternative rules that accomplish the stated purpose of the Affordable Care Act and minimize the impact on small entities.

D. Special Analyses--Department of the Treasury

Notwithstanding the determinations of the Department of Labor and Department of Health and Human Services, for purposes of the Department of the Treasury, it has been determined that this Treasury decision is not a significant regulatory action for purposes of Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the APA (5 U.S.C. chapter 5) does not apply to these interim final regulations. For the applicability of the RFA, refer to the Special Analyses section in the preamble to the cross-referencing notice of proposed rulemaking published elsewhere in this issue of the Federal Register. Pursuant to section 7805(f) of the Code, these temporary regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small businesses.

E. Paperwork Reduction Act: Department of Labor, Department of the Treasury, and Department of Health and Human Services

These interim final regulations are not subject to the requirements of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.) because it does not contain a ``collection of information'' as defined in 44 U.S.C. 3502 (11).

F. Congressional Review Act

These interim final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and have been transmitted to Congress and the Comptroller General for review.

G. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of \$100 million (as adjusted for inflation) by State, local and tribal governments or the private sector. These interim final regulations are not subject to the Unfunded Mandates Reform Act because they are being issued as interim final regulations. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, these interim final regulations have been designed to be the least burdensome alternative for State, local and tribal governments, and the private sector, while achieving the objectives of the Affordable Care Act.

H. Federalism Statement--Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have ``substantial direct effects'' on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments' view, these interim final regulations have federalism implications, because they have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. However, in the Departments' view, the federalism implications of these interim final regulations are substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States will enact laws or take other appropriate action resulting in their meeting or exceeding the

Federal standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement'' of a Federal standard. The conference report accompanying HIPAA indicates that this is intended to be the ``narrowest'' preemption of State laws. (See House Conf. Rep. No. 104-736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.) States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the Federal requirements are unlikely to prevent the application of the Affordable Care Act, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit

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the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected State and local officials, including attending conferences of the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis. It is expected that the Departments will act in a similar fashion in enforcing the Affordable Care Act requirements. Throughout the process of developing these interim final regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to these interim final regulations, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached regulations in a meaningful and timely manner.

V. Recommended Preventive Services as of July 14, 2010

The materials that follow list recommended preventive services, current as of July 14, 2010, that will have to be covered without cost-sharing when delivered by an in-network provider. In many cases, the recommendations or guidelines went into effect before September 23, 2009; therefore the recommended services must be covered under these interim final regulations in plan years (in the individual market, policy years) that begin on or after September 23, 2010. However, there are some services that appear in the figure that are based on recommendations or guidelines that went into effect at some point later than September 23, 2009. Those services do not have to be covered under these interim final regulations until plan years (in the individual market, policy years) that begin at some point later than September 23, 2010. In addition, there are a few recommendations and guidelines that went into effect after September 23, 2009 and are not included in the figure. In both cases, information at <http://www.HealthCare.gov/center/regulations/prevention.html> specifically identifies those services and the relevant dates. The materials at <http://www.HealthCare.gov/center/regulations/prevention.html> will be updated on an ongoing basis, and will contain the most current recommended preventive services.

A. Recommendations of the United States Preventive Services Task Force (Task Force)

Recommendations of the Task Force appear in a chart that follows. This chart includes a description of the topic, the text of the Task Force recommendation, the grade the recommendation received (A or B), and the date that the recommendation went into effect.

B. Recommendations of the Advisory Committee On Immunization Practices (Advisory Committee) That Have Been Adopted by the Director of the Centers for Disease Control and Prevention

Recommendations of the Advisory Committee appear in four immunization schedules that follow: A schedule for children age 0 to 6 years, a schedule for children age 7 to 18 years, a ``catch-up'' schedule for children, and a schedule for adults. Immunization schedules are issued every year, and the schedules that appear here are the 2010 schedules. The schedules contain graphics that provide information about the recommended age for vaccination, number of doses

needed, interval between the doses, and (for adults) recommendations associated with particular health conditions. In addition to the graphics, the schedules contain detailed footnotes that provide further information on each immunization in the schedule.

C. Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA) for Infants, Children, and Adolescents

Comprehensive guidelines for infants, children, and adolescents supported by HRSA appear in two charts that follow: The Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.
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VI. Statutory Authority

The Department of the Treasury temporary regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

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The Department of Labor interim final regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161-1168, 1169, 1181-1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104-191, 110 Stat. 1936; sec. 401(b), Pub. L. 105-200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110-343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111-148, 124 Stat. 119, as amended by Pub. L. 111-152, 124 Stat. 1029; Secretary of Labor's Order 6-2009, 74 FR 21524 (May 7, 2009).

The Department of Health and Human Services interim final regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 USC 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

Steven T. Miller,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: July 8, 2010
Michael F. Mundaca,

Assistant Secretary of the Treasury (Tax Policy).

Signed this 9th day of July, 2010.
Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration,
Department of Labor.

Dated: July 9, 2010
Jay Angoff,

Director, Office of Consumer Information and Insurance Oversight.

Dated: July 9, 2010.
Kathleen Sebelius,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Chapter 1

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Accordingly, 26 CFR Part 54 is amended as follows:

PART 54--PENSION EXCISE TAXES

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Paragraph 1. The authority citation for part 54 is amended by adding an entry for Sec. 54.9815-2713T in numerical order to read in part as follows:

Authority: 26 U.S.C. 7805. * * *

Section 54.9815-2713T also issued under 26 U.S.C. 9833. * * *

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Par. 2. Section 54.9815-2713T is added to read as follows:

Sec. 54.9815-2713T Coverage of preventive health services (temporary).

(a) Services--(1) In general. Beginning at the time described in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(2) Office visits--(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iv) The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Facts. An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) Conclusion. In this Example 1, the plan may not impose any cost-sharing requirements with respect to the separately-

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billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2. (i) Facts. Same facts as Example 1. As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.

(ii) Conclusion. In this Example 2, because the treatment is not included in the recommendations under paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

Example 3. (i) Facts. An individual covered by a group health

plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 3, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) Facts. A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 4, the service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

(3) Out-of-network providers. Nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider. Moreover, nothing in this section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(4) Reasonable medical management. Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the recommendation or guideline.

(5) Services not described. Nothing in this section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A plan or issuer may impose cost-sharing requirements for a treatment not described in paragraph (a)(1) of this section, even if the treatment results from an item or service described in paragraph (a)(1) of this section.

(b) Timing--(1) In general. A plan or issuer must provide coverage pursuant to paragraph (a)(1) of this section for plan years that begin on or after September 23, 2010, or, if later, for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) Changes in recommendations or guidelines. A plan or issuer is not required under this section to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section after the recommendation or guideline is no longer described in paragraph (a)(1) of this section. Other requirements of Federal or State law may apply in connection with a plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective.

(c) Recommendations not current. For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(d) Effective/applicability date. The provisions of this section apply for plan years beginning on or after September 23, 2010. See Sec. 54.9815-1251T for determining the application of this section to grandfathered health plans (providing that these rules regarding coverage of preventive health services do not apply to grandfathered health plans).

(e) Expiration date. This section expires on July 12, 2013 or on such earlier date as may be provided in final regulations or other action published in the Federal Register.

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

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29 CFR Part 2590 is amended as follows:

PART 2590--RULES AND REGULATIONS FOR GROUP HEALTH PLANS

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1. The authority citation for Part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161-1168, 1169, 1181-1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104-191, 110 Stat. 1936; sec. 401(b), Pub. L. 105-200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110-343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111-148, 124 Stat. 119, as amended by Pub. L. 111-152, 124 Stat. 1029; Secretary of Labor's Order 6-2009, 74 FR 21524 (May 7, 2009).

Subpart C--Other Requirements

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2. Section 2590.715-2713 is added to subpart C to read as follows:

Sec. 2590.715-2713 Coverage of preventive health services.

(a) Services--(1) In general. Beginning at the time described in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been

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adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(2) Office visits--(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iv) The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Facts. An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) Conclusion. In this Example 1, the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2. (i) Facts. Same facts as Example 1. As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the

recommendations under paragraph (a)(1) of this section.

(ii) Conclusion. In this Example 2, because the treatment is not included in the recommendations under paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

Example 3. (i) Facts. An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 3, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) Facts. A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 4, the service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

(3) Out-of-network providers. Nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider. Moreover, nothing in this section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(4) Reasonable medical management. Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the recommendation or guideline.

(5) Services not described. Nothing in this section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A plan or issuer may impose cost-sharing requirements for a treatment not described in paragraph (a)(1) of this section, even if the treatment results from an item or service described in paragraph (a)(1) of this section.

(b) Timing--(1) In general. A plan or issuer must provide coverage pursuant to paragraph (a)(1) of this section for plan years that begin on or after September 23, 2010, or, if later, for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) Changes in recommendations or guidelines. A plan or issuer is not required under this section to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section after the recommendation or guideline is no longer described in paragraph (a)(1) of this section. Other requirements of Federal or State law may apply in connection with a plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective.

(c) Recommendations not current. For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(d) Applicability date. The provisions of this section apply for plan years beginning on or after September 23, 2010. See Sec. 2590.715-1251 of this Part for determining the application of this section to grandfathered health plans (providing that these rules regarding coverage of preventive health services do not apply to grandfathered health plans).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Subtitle A

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For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR part 147, added May 13, 2010, at 75 FR 27138, effective July 12, 2010, as follows:

PART 147--HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

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1. The authority citation for part 147 continues to read as follows:

Authority: Sections 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

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2. Add Sec. 147.130 to read as follows:

Sec. 147.130 Coverage of preventive health services.

(a) Services--(1) In general. Beginning at the time described in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(2) Office visits--(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iv) The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Facts. An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) Conclusion. In this Example 1, the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2. (i) Facts. Same facts as Example 1. As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.

(ii) Conclusion. In this Example 2, because the treatment is not

included in the recommendations under paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

Example 3. (i) Facts. An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 3, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) Facts. A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 4, the service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement for the office visit charge.

(3) Out-of-network providers. Nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider. Moreover, nothing in this section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(4) Reasonable medical management. Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the recommendation or guideline.

(5) Services not described. Nothing in this section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A

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plan or issuer may impose cost-sharing requirements for a treatment not described in paragraph (a)(1) of this section, even if the treatment results from an item or service described in paragraph (a)(1) of this section.

(b) Timing--(1) In general. A plan or issuer must provide coverage pursuant to paragraph (a)(1) of this section for plan years (in the individual market, policy years) that begin on or after September 23, 2010, or, if later, for plan years (in the individual market, policy years) that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) Changes in recommendations or guidelines. A plan or issuer is not required under this section to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section after the recommendation or guideline is no longer described in paragraph (a)(1) of this section. Other requirements of Federal or State law may apply in connection with a plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective.

(c) Recommendations not current. For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(d) Applicability date. The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. See Sec. 147.140 of this Part for determining the application of this section to grandfathered health plans (providing that these rules regarding coverage of preventive health services do not apply to grandfathered health plans).

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