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Preventive Care Coverage Guidelines Issued

July 29, 2010

The Patient Protection and Affordable Care Act requires new health plans to cover preventive health services without imposing cost-sharing requirements for the services. On July 14, 2010, the Departments of Health and Human Services (HHS), Labor, and Treasury issued interim final rules relating to coverage of preventive services. This requirement is generally effective for **plan years beginning on or after September 23, 2010**. It does not apply to grandfathered health plans.

Highlights of the regulations include:

- An explanation of the recommended preventive services that must be covered without cost-sharing requirements;
- Clarification regarding cost-sharing that may be imposed when preventive services are provided during an office visit; and
- Confirmation that cost-sharing can be imposed for out-of-network services.

SUMMARY OF THE REGULATIONS

-Coverage of Preventive Services

The interim final rules address the requirement that new (i.e., non-grandfathered) health plans cover certain recommended preventive services and eliminate cost-sharing requirements for such services. For plan years beginning on or after September 23, 2010, new group health plans must cover certain preventive services and may not charge copayments, coinsurance or deductibles for these services when delivered by a network provider.

The recommended preventive services covered by these requirements are:

- 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;
- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines; and
- For women, evidence-informed preventive care and screening provided in guidelines supported by HRSA, which are to be developed by August 1, 2011.

These recommended preventive services include screening for a number of conditions, as well as counseling for various health-related issues. The complete list of recommended preventive services that must be covered can be found at http://www.healthcare.gov/law/about/provisions/services/lists.html.

-Office Visits

The interim final rules clarify the cost-sharing requirements when a recommended preventive service is provided during an office visit. Whether cost-sharing requirements may be imposed will depend on: (a) whether the preventive service is billed or tracked separately, and (b) whether the preventive service is the primary purpose of the office visit.

- Cost-sharing is permitted only if:
  - The recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit; or
  - The recommended preventive service is not billed separately from the office visit and the primary purpose of the office visit is not to obtain the recommended preventive service.

- Cost-sharing is **not** permitted if:
  - The recommended preventive service is not billed separately from the office visit but it is the primary purpose of the office visit.

-Additional Clarifications

The regulations make clear that plans may continue to impose cost-sharing requirements on preventive services that employees receive from out-of-network providers. Also, plans may use reasonable medical management techniques to determine the frequency, method, treatment or setting for preventive services, as long as they are not specified in the recommendation or guideline.

For additional information please click on the following link or contact your Lawley Benefits Consultant:

http://www.healthcare.gov/law/about/provisions/services/background.html