Health Care Reform: Preventive Care Coverage Guidelines

The Patient Protection and Affordable Care Act requires *non-grandfathered* 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 Sept. 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.

This Benefit Administration Company, LLC. Legislative Brief summarizes the new interim final rules. The rules are available at http://edocket.access.gpo.gov/2010/pdf/2010-17242.pdf.

SUMMARY OF THE REGULATIONS

Coverage of Preventive Services

The interim final rules address the requirement that non-grandfathered health plans cover certain recommended preventive services and eliminate cost-sharing requirements for such services. For plan years beginning on or after Sept. 23, 2010, non-grandfathered 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 Aug. 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 www.HealthCare.gov/center/regulations/prevention.html.

*On Aug. 1, 2011, HHS issued new preventive care guidelines for women. These new guidelines require non-grandfathered health plans to cover women's preventive health services (such as well-woman visits, breastfeeding support, domestic violence screening and contraceptives) without charging a copayment, a deductible or coinsurance. Non-grandfathered health plans will need to include these services without cost-sharing **for plan years beginning on or after Aug. 1, 2012** (Jan. 1, 2013, for calendar year plans).

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 requirements are not allowed in cases where the recommended preventive service is not billed separately, but it is the primary purpose of the office visit.

Example. An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is given a cholesterol screening (a recommended preventive service). The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test. The plan may not impose any cost-sharing requirements with respect to the laboratory work. Because the office visit is billed separately from the cholesterol test, the plan may impose cost-sharing requirements for the office visit.

Example. 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 (a recommended preventive service). The provider bills the plan for an office visit. The blood pressure screening was not the primary purpose of the visit. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example. A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam (a recommended preventive service). During the office visit, the child receives additional items and services that are not recommended preventive services. The provider bills the plan for an office visit. The recommended preventive service was not billed as a separate charge and was the primary purpose of the visit. Therefore, the plan may not impose a cost-sharing requirement for 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.