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# Health Care Reform: Preventive Services Interim Final Rules Released

**July 22, 2010**

On July 14, 2010, the Departments of Labor, Health and Human Services and Treasury released final interim rules implementing the preventive health services provisions under the Affordable Care Act (the "Act").[1] The agencies also released a Fact Sheet. The rules were published in the July 19, 2010 Federal Register.

The rules are designed to make preventive health services accessible and affordable by (1) requiring coverage of recommended preventive health services that have strong scientific evidence of their health benefits and (2) not charging plan participants co-payments, co-insurances or deductibles for these services when they are delivered by an in-network provider.

The rules are generally effective as to group health plans and health insurance issuers offering group and individual health insurance coverage for plan years beginning on or after September 23, 2010 (*i.e.*, January 1, 2011 for calendar-year plans). For recommendations or guidelines that have been in effect for less than one year, group health plans and issuers offering group and individual health insurance coverage that are not grandfathered health plans (Non-Grandfathered Plans) will have one year from the effective date to comply, if later.

These rules do not apply to grandfathered health plans. To be a grandfathered health plan, the plan must have been in existence on March 23, 2010, complied with the federal agency rules on maintaining grandfathered health plan status, and not have been amended since that date in a way to cause the plan to lose grandfathered status. Employers considering whether to retain grandfathered health plan status will want to weigh the costs and benefits of complying with this mandate. (Click on this alert: "Health Care Reform: Grandfathered Health Plan Interim Final Regulations Released" for more information on grandfathered health plans).

**Recommended Preventive Health Services**

Under the new rules, a Non-Grandfathered Plan must provide benefits for and prohibit the imposition of cost-sharing requirements (including co-payments, co-insurance or deductibles) 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.
- 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 Diseased Control and Prevention with respect to the individual involved.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force). HHS is developing these guidelines and expects to issue them no later than August 1, 2011.

Any future changes to a recommendation or guideline for a preventive service by the above-referenced agencies will also be noted at this website. Until new recommendations are issued by the Task Force or comprehensive guidelines are released by HRSA, the Task Force’s recommendations concerning such preventive care and screenings for women that were issued before November 2009 will generally apply for this purpose. (Recommendations of the Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.) See the “Recommended Preventive Services” at the link above for more information.

**Preventive Health Services Not Recommended**

Non-Grandfathered Plans may continue to impose cost-sharing requirements to cover those preventive services that are not required to be covered by the Act. Moreover, nothing prohibits the imposition of cost-sharing requirements for treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

The preventive service coverage or cost-sharing requirements are not applicable for any item or service that has ceased to be a recommended preventive service. (However, other federal or state requirements may apply in connection with the discontinuance of preventive services or the changing of cost-sharing requirements for any such item or service (*e.g.*, the Act requires that the participants receive 60-days advanced notice of any material modification before it becomes effective under the group health plan or health insurance policy)).

**Cost-Sharing when Preventive Services Provided as Part of Office Visit**

The following are a series of rules and examples on how to apply the cost-sharing requirement for office visits during which recommended preventive services are rendered.

- Cost-Sharing for Office Visit Allowed. If a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit where the primary purpose of the visit was for preventive services, then Non-Grandfathered Plans may impose a cost-sharing requirement with respect to the office visit.
- Cost-Sharing for Office Visit Not Allowed. If recommended preventive services are not billed separately (or are tracked as individual encounter data) from an office visit and the primary purpose of the visit was the delivery of a recommended preventive service or item, then Non-Grandfathered Plans may not impose cost-sharing requirements for such visit.
- Cost-Sharing for Office Visit Allowed. Regardless of whether recommended preventive services are billed separately (or are tracked as individual encounter data) from an office visit, if the primary purpose of the office visit was not to provide a recommended preventive service or item, then a cost-sharing requirement may be imposed on the office visit. In addition, a plan could, in this case, exclude coverage for the office visit entirely to the extent otherwise permitted under applicable law.

*Example 1.* An individual covered by a non-grandfathered 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 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. 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.* 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 noted above. Because the treatment is not included in the recommendations, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

*Example 3.* An individual covered by a non-grandfathered 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 Task Force with respect to the individual. The provider bills the plan for an office visit. The blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver recommended preventive items or services. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

*Example 4.* A child covered by a non-grandfathered group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the HRSA. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the HRSA, nor otherwise included in the recommendations noted above. The provider bills the plan for an office visit. 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 HRSA. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

### Cost-Sharing Permitted for Out-of-Network Providers

Non-Grandfathered Plans that offer coverage through a network of providers are not required to provide coverage for recommended preventive services delivered by an out-of-network provider and may impose cost-sharing requirements for the delivery of such services by an out-of-network provider.

### Reasonable Medical Management Techniques Permitted

If a recommendation or guideline for a preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, the Non-Grandfathered Plans can use "reasonable medical management techniques" to determine any coverage limitations.

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We will continue to monitor these and other coverage mandates under the Act, and provide updates as guidance becomes available.

[1] The "Affordable Care Act" means The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA).

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