Preventive Care Services Regulations Released

PARKER | SMITH | FEEK

July 2010

Summary

The IRS, DOL and HHS (The Agencies) have jointly released regulations (The Regulations) regarding the preventive care coverage requirements contained in The Patient Protection and Affordable Care Act of 2010 (ACA). The Regulations, which will be published in the Federal Register on July 19th, define the preventive health services that a health plan must provide coverage for with no cost-sharing requirements such as a copayments, coinsurance, or deductibles. The rules do not apply to grandfathered health plans.

Required preventive services fall into four (4) categories:

- Evidence-based items or services with 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 with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control.
- With respect to infants, children, and adolescents, evidence-based preventive care and screenings included in guidelines supported by the Health Resources and Services Administration.
- With respect to women, evidence-based preventive care and screenings included in guidelines supported by the Health Resources and Services Administration.

A health plan is allowed to use reasonable medical management techniques to determine specific coverage levels related to frequency of service, care setting, or methods of treatment, if the recommendations in force do not define these aspects of the required preventive services.

A general description of covered services targeted to the public can be found at http://www.healthcare.gov/law/about/provisions/services/lists.html. A more comprehensive list of services and recommendations included in all of the categories can be found at: http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

Out-of-network providers

For plans that include in and out of network providers, cost sharing such as co-pays and deductibles can continue to apply to services provided by out-of-network providers.

Office visits

The Regulations also provide guidance and examples as to how preventive services must be covered depending on how the service is billed by the provider. For example, if a covered preventive care service is billed separately from an office visit, then the plan may impose cost-sharing requirements with respect to the office visit, but not the charge for the preventive service. On the other hand, if a covered preventive service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of the preventive service, then a plan may not impose cost-sharing requirements with respect to the entire office visit.

Cost Impact

The Regulations include an estimate of the cost impact the required services will have on health plan premiums. While the cost impact on any particular plan will obviously depend largely on what preventive benefits are currently offered, overall the analysis predicts an average premium increase for all individual and group plans of 1.5%. It is expected that individual plans will experience increases slightly above this average and group plans will experience a lower average increase.

Effective Date

For preventive services with recommendations in force prior to September 23, 2009, a plan must provide coverage for plan years that begin on or after September 23, 2010. New recommendations made after September 23, 2009 must be implemented for plan years that begin one year after the date the recommendation or guideline is issued.