

Federal Agencies Issue Interim Final Regulations For Preventive Care Services

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (together, the "Health Care Reform Law") require non-grandfathered group health plans to cover certain preventive care services (such as mammograms, colonoscopies and immunizations) without cost-sharing. Specifically, the services required to be covered are (i) evidence-based items or services rated "A" or "B" in current recommendations by the United States Preventive Services Task Force; (ii) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; (iii) evidence-informed preventive care and screenings for infants, children and adolescents, identified in comprehensive guidelines supported by the Health Resources and Services Administration; and (iv) additional preventive care and screenings for women, identified in the comprehensive guidelines supported by the Health Resources and Services Administration. The new requirements are generally effective for plan years beginning after September 23, 2010 (i.e., January 1, 2011 for calendar year plans).

The IRS, DOL and HHS have jointly issued interim final regulations addressing the new requirements for preventive care services. Here are some of the highlights.

- The preamble to the interim final regulations includes a link to a website with a complete list of recommendations and guidelines for services that are required to be covered.
- If a preventive care service is provided during an office visit, cost-sharing requirements may be imposed for the office visit if (i) the preventive care service is billed separately or (ii) the preventive care service is not billed separately, but the primary purpose of the office visit is not delivery of the preventive care service. If the preventive care service is not billed separately, and the primary purpose of the office visit is delivery of the preventive care service, then cost-sharing requirements may not be imposed for the office visit.
- If the health care plan or insurance coverage uses a network of providers, cost-sharing requirements may be imposed, or coverage need not be provided at all, for required preventive care services delivered by an out-of-network provider.
- If a recommendation or guideline does not specify the frequency, method, treatment or setting for provision of a preventive care service, the health care plan or insurance carrier may use reasonable medical management techniques to establish any coverage limitations.
- If a plan or insurance carrier covers preventive care services in addition to those required, the plan or carrier may impose cost-sharing requirements on those additional services at its discretion.
- Plans and insurance carriers must cover required preventive care services for plan years that begin on or after the later of September 23, 2010 or one year after the date the recommendation or guideline addressing the preventive care service is issued. In addition, plans or insurance carriers are not required to cover or waive cost-sharing requirements for preventive care services that have ceased to be included among the required recommendations and guidelines. This should allow group health plans and insurance carriers to visit the government website once per year and update their coverages accordingly for the next plan year.

If you have questions or would like additional information about these new requirements for coverage of preventive care services under the Health Care Reform Law, please feel free to contact Brian Dougherty at (215) 587-5919 or bdougherty@postschell.com.

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