

BRUCKER



MORRA

A Professional Corporation

## *on Benefits*

*Exclusively practicing employee benefits law ♦ ERISA ♦ and benefits taxation*

### Attorneys

- Alex M. Brucker
- Linda Russano Morra
- Michael L. Cotter
- Meredith J. Sesser
- Cathryn B. Sportsman
- Jeremy M. Pelphey

T: (310) 475-7540

F: (310) 470-4806

W: [www.pensionlawyers.com](http://www.pensionlawyers.com)

## Interim Final Regulations Issued for Health Plans Requiring Preventive Health Services Without Cost Sharing

**Jeremy M. Pelphey**  
**July 16, 2010**

On July 14, 2010, the three primary agencies charged with regulating and enforcing the federal government's health care reform effort (the U.S. Department of Treasury, the U.S. Department of Health and Human Services, and the U.S. Department of Labor) released their latest set of interim final regulations implementing provisions of the Public Health Services Act that require non-grandfathered health plans (see our June 15, 2010 *On Benefits* for a discussion of the interim final regulations pertaining to grandfathered health plans) to cover preventive services and to eliminate cost-sharing requirements (e.g., deductible and co-payments) for such services under the Patient Protection and Affordable Care Act and the subsequent Reconciliation Act (collectively, "PPACA").

In this *On Benefits*, we review the latest set of interim final regulations and explore how the new rules will help enforce the health care reform provisions.

**The Basic Rule.** For plan years beginning on or after September 23, 2010, new health plans and non-grandfathered group health plans must cover preventive services that have strong scientific evidence of their health benefits, and these plans may no longer charge patients a co-payment, co-insurance or de-

ductible for these services when they are delivered by a network provider. However, any state insurance laws that impose on health insurance issuers requirements stricter than those imposed by the PPACA will not be superseded by the PPACA.

**Preventive Services Covered.** The preventive services these regulations apply to include:

- 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 Disease Control and Prevention (CDC) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the CDC. A recommendation is considered to be for routine use if it appears on the Immunization Sched-

ules of the CDC.

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (and not otherwise addressed by the recommendations of the Task Force). HHS expects to issue guidelines no later than August 1, 2011.

The complete list of preventive services recommendations and guidelines that must be covered under the interim final regulations can be found at: <http://www.HealthCare.gov/center/regulations/prevention.html>.

**Elimination of Cost-Sharing.** The interim final regulations clarify the cost-sharing requirements when a recommended preventive service is provided during an office visit:

- If a recommended preventive service is billed separately (or is tracked separately as individual encounter data) from an office visit, then a plan or issuer may apply cost-sharing requirements with respect to the office visit.
- If a recommended preventive service is not billed separately (or is not tracked separately as individual encounter data) from an office visit and the primary purpose of the office visit is the delivery of such a preventive

item or service, then a plan or issuer *may not* apply cost-sharing requirements with respect to the office visit.

- Finally, if a recommended preventive service is not billed separately (or is not tracked separately as individual encounter data) from an office visit and the primary purpose of the office visit is *not* the delivery of such a preventive item or service, then a plan or issuer *may* apply cost-sharing requirements with respect to the office visit.

For *example*, an individual covered by a 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 U.S. Preventive Services 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. Under these facts, the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. However, because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Plans that cover preventive services in addition to those required under the new law may apply cost-sharing requirements for the additional services. Also, where there is no frequency, method, treatment, or setting specified for the recommended preventive service, the plan can use reasonable medical management techniques to determine any coverage limitations.

The regulations further clarify that group health plans are not required to provide coverage for recommended preventive

services delivered by an out-of-network provider. Thus, a plan or issuer may impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider.

**Effective Date.** When new recommended preventive services are named under the law, there is an interval of not less than one year between when recommendations or guidelines under Public Health Services Act are issued and the plan year for which coverage of the services addressed in such recommendations or guidelines must be in effect. Under the interim final regulations, coverage for a recommended preventive service generally must be provided for plan years beginning on or after the later of September 23, 2010, or one year after the date the recommendation or guideline for the preventive service is issued. Thus, recommendations and guidelines issued prior to September 23, 2009, must be provided for plan years (in the individual market, “policy years”) beginning on or after September 23, 2010.

The interim final regulations are scheduled for publication in the July 19, 2010 *Federal Register*. As we previously noted, we expect to see additional guidance from the three primary agencies in the coming months. Brucker & Morra, APC will provide updates as they become available.

#### DISCLAIMER

The information contained herein is provided by Brucker & Morra, APC as general information to clients and friends. It should not be construed as, and does not constitute, legal advice on any specific matter, nor does this message create an attorney-client relationship. These materials may be considered ATTORNEY ADVERTISING in some states.