



Health Care Reform News

Health Care Reform — Recommended preventive care at no cost to plan members

August 24, 2010 — A new regulation released by the Department of Health and Human Services (HHS), the Department of Treasury, and the Department of Labor requires group health plans to **cover recommended preventive services without charging plan members a copay, coinsurance, or deductible.**

When does this requirement take effect?

Plans must provide benefits for recommended preventive services and remove cost sharing for these services with the start of plan years that begin on or after September 23, 2010.

Are “grandfathered” plans exempt?

Yes. Grandfathered plans can exclude benefits for, or apply cost sharing to, recommended preventive services until 2014.

OUT-OF-NETWORK SERVICES

These requirements apply to recommended preventive services that plan members receive from network health care providers. Plans may exclude coverage entirely for preventive services performed by out-of-network health care providers. Or plans may apply copays, deductible, or coinsurance to out-of-network services.

COST SHARING REQUIREMENTS FOR OFFICE VISITS AND PREVENTIVE CARE

If an individual visits a doctor for the primary purpose of receiving recommended preventive services:

- the plan **may not apply** cost sharing to the **preventive service**; and
- the plan **may not apply** cost sharing to the **office visit**;
- even if the doctor bills for them **separately**.

If an individual visits a doctor and receives a recommended preventive service, but the preventive service is not the primary purpose of the visit:

- the plan **may apply** cost sharing to the **office visit**; however
- the plan **may not apply** cost sharing to the **recommended preventive service**;
- Example 1 — An individual visits a network doctor for care for abdominal pain. While she is in the office, she also receives a cholesterol screening test. The office bills for the visit and the cholesterol test together. The primary purpose of the visit was **not** the cholesterol test so the plan **may apply cost sharing to the office visit**.
- Example 2 — An individual receives a cholesterol screening test, which is a recommended preventive service, from a network doctor during a routine office visit. The office bills for the recommended preventive service as a separate charge. The plan **may apply cost sharing to the office visit**.

WHAT ARE RECOMMENDED PREVENTIVE SERVICES?

The Patient Protection and Affordable Care Act (Act) requires plans to cover the following **recommended preventive services** with no cost sharing when a network health care provider performs them:

- Evidence-based items or services listed as Grade A or B recommendations in the U.S. Preventive Services Task Force Recommendations. You can [view the list online](http://www.Healthcare.gov) at www.Healthcare.gov.
- Immunizations included in the recommended immunization schedules from The Centers for Disease Control and Prevention (CDC). You can view the immunizations schedules at <http://www.HealthCare.gov/center/regulations/prevention.html>. The schedules are based on the individual's age and include:
 - [Recommended immunizations for children age 0-6](#)
 - [Recommended immunizations for children 7-18](#)
 - [Catch-up immunizations for those age 4 months through 18 years who start late or are more than one month behind](#)
 - [Recommended immunization schedule for adults](#)
 - Preventive care and screening for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)
 - Guidelines for women supported by HRSA

Treatment that is not a recommended preventive service

A plan can choose to cover additional preventive services that are not listed as recommended preventive services. Plans can apply cost sharing to the additional services only.

Furthermore, a plan can apply cost sharing to a service that is not a recommended preventive service, even if it results from a recommended preventive service.

Reasonable medical management

If a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of the service, the plan can use reasonable medical management techniques to determine any coverage limitations.

Changes to the recommended preventive services lists and guidelines

Services may be added to or removed from the recommended preventive services. Guidelines, such as frequency or setting, can change. The lists on Healthcare.gov will reflect any changes.

The Act allows at least one year for plans to comply with changes to the list of recommended preventive services. So, for example, plans would not need to begin covering a service that is added to the recommended preventive services before the start of the first plan year that begins after the new service or guideline takes effect.

Other requirements of federal or state law may apply if a plan considers discontinuing coverage or changing cost sharing requirements for a service that is removed from the recommended preventive services. For example, health care reform regulations require a plan to give plan members 60 days' advance notice before any material modification to the plan takes effect.

NEXT STEPS FOR PLAN SPONSORS

Be sure to take these important steps:

- **Plan documents.** It is very important that you amend your plan documents to reflect any changes you make.
- **Stop loss coverage.** Be sure to notify your stop loss carrier promptly of any changes you make.

FOR MORE INFORMATION

You can find information about health care reform online:

- [View the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act](#)
- [Read about the recommended preventive services, including links to list of the recommended preventive services and immunization schedules by age](#)
- [See a list of covered preventive services](#)
- [View more detailed information about covered services](#)

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