



Employee Benefits Law Action Memo

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Electronic Dispatch

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PREVENTIVE CARE COVERAGE REQUIREMENTS UNDER HEALTH REFORM

One consequence of losing grandfathered plan status in an employment-based group health plan is the requirement that specified preventive services must be covered on a “first dollar” basis. This means that the specified preventive care services may not be subject to a deductible, co-payment, or other cost-sharing requirement. The agencies jointly responsible for enforcing the Patient Protection and Affordable Care Act (“Affordable Care Act”) – the Internal Revenue Service, the U.S. Department of Labor Employee Benefit Security Administration, and the Department of Health and Human Services – jointly published interim final regulations (“Regulations”) relating to the coverage of preventive care services on July 19, 2010. The Regulations apply to new plans and to non-grandfathered group health plans for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans).

Preventive Care Services

The Affordable Care Act requires that group health plans and health insurance issuers provide first dollar coverage for:

- Evidence-based items or services that are highly rated by the U.S. Preventive Services Task Force. The regulations list those recommended items and services as of July 14, 2010. The list details 44 items, including such services as screenings for diabetes, blood pressure, cervical, colorectal and breast cancer, certain sexually transmitted diseases, and many services related to pregnancy and childbirth.
- Immunizations recommended for routine use in children, adolescents and adults by the Centers for Disease Control and prevention, which the regulations define to include such routine childhood vaccines as Measles, Mumps, Rubella, Hepatitis A and B, Tetanus, Diphtheria, Pertussis, and Inactivated Poliovirus, as well as adult immunization for HPV, Meningococcal, Influenza and Zoster, among others.
- Evidence-informed preventive care and screenings for women, infants, children and adolescents that are contained in guidelines supported by the Health Resources and Services Administration.

A complete list of required preventive services and items required under the Regulations is available at <http://www.HealthCare.gov/center/regulations/prevention.html>. If additional preventive care services and items are added to the list, the Affordable Care Act requires that there be a minimum interval of one year between the date the recommendations are issued and the plan year in which first dollar coverage must be provided. If a preventive service or item is dropped from the list, the plan may drop the coverage, or impose cost-sharing, with 60 days advance notice to the enrollee.

A group health plan or issuer may provide additional preventive care services beyond those contained in the current requirements, with or without cost-sharing, in its discretion.

If the preventive care recommendation or guideline does not specify how, or how often, the service or item is to be delivered, the Regulations permit the health plan or issuer to use reasonable medical management techniques to determine coverage limitations, such as the frequency, method, treatment, or setting in which the recommended preventive service will be available without cost-sharing.

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When Preventive Care is Provided with Other Services

The Regulations recognize that many preventive care services are rendered in connection with other services in an office visit, and contain guidance regarding how the “first-dollar” rule applies in those circumstances. The standard rule is, if the preventive service is billed separately, cost-sharing may be imposed with respect to the office visit. In cases where the preventive service is not billed separately (or, in capitation or similar payment situations, there is no separate tracking of the individual encounter data), the following rules apply:

- If the primary purpose for the office visit is the preventive service, no cost-sharing may be imposed for the office visit; and
- If the primary purpose of the visit is not the preventive service, the health plan may impose the applicable cost-sharing requirements to the office visit.

In-Network vs. Out-of-Network Preventive Services

The Regulations specify that a health plan that differentiates between services provided by in-network providers and those available from out-of-network providers is not required to provide coverage for recommended preventive services and items delivered by an out-of-network provider. If such services are delivered by an out-of-network provider, they may be subject to the cost-sharing requirements of the health plan.

The Economic Impact of First Dollar Preventive Services

One of the key considerations employers face regarding whether to maintain grandfather status in a health plan is the cost effect of first-dollar preventive services (see the June, 2010, BS&K Employee Benefit Information Memorandum to determine what plan changes affect grandfather status). The federal Office of Management and Budget has determined that these regulations are economically significant because they are likely to have an annual effect on the economy of \$100 million in any one year. For non-grandfathered group health plans, because preventive care expenses that were previously paid out-of-pocket will be covered by group health plans and issuers, the demand for these services will likely increase, and the cost of these services will likely result in higher premiums. Your insurer, insurance broker, or health plan actuary may be able to estimate the actual cost to any particular group health plan.

If you have any questions about this memorandum, please contact Amelia M. Klein in our Albany office (518-533-3217, aklein@bsk.com) or any of the other members of our Employee Benefits and Executive Compensation Practice Group listed below.

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