

HEALTH REFORM IMPACT

What you need to know NOW

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

New Preventive Care Rules for Group Health Plans

August 9, 2010

The Departments of Health and Human Services, Labor, and Treasury recently issued interim final regulations under health reform legislation regarding coverage for preventive services. The regulations are effective for plan years beginning on or after September 23, 2010; however, "grandfathered" health plans continue to be exempt from the regulations so long as they retain that status.¹

Under the regulations, group health plans are required to offer coverage and eliminate cost-sharing requirements for certain enumerated preventive services. This means that cost-sharing requirements (such as copayments, coinsurance or deductibles) will not be permitted when these preventive services are rendered. However, the regulations clarify that cost-sharing requirements for related office visits or treatments may be applied under certain circumstances. The regulations provide the following examples which illustrate the circumstances in which cost-sharing requirements may be imposed:

- If a recommended preventive service is billed separately from an office visit, a plan may require cost-sharing for the office visit. For example, during an office visit an individual is tested for high cholesterol. The provider bills for the office visit and the lab work separately. While the plan may not impose cost-sharing on the lab work, the regulations provide that because the office visit is billed separately, the plan may impose cost-sharing on the office visit.
- If a recommended preventive service is NOT billed separately from an office visit AND the primary purpose of the office visit is the delivery of the preventive service, the plan may not impose cost-sharing on the office visit. For example, during a well-child exam additional services that are not recommended preventive services are provided. The provider bills the plan only for the office visit. Because (i) the preventive service is billed as part of an office visit rather than as a separate charge, and (ii) the primary purpose of the office visit is to deliver recommended preventive services, the plan may not impose cost-sharing on the office visit.

¹ See previous Health Reform IMPACT Alerts on what "grandfathering" means for a plan and how "grandfathered" status may be lost by clicking [here](#) and [here](#).

- If a recommended preventive service is not billed separately from an office visit but the primary purpose of the office visit is NOT the delivery of such recommended preventive service, the plan may impose cost-sharing on the office visit. For example, an individual visits the provider for recurring abdominal pain and is also tested for high blood pressure (a recommended service) during the office visit. Here, the plan may impose cost-sharing on the office visit because the primary purpose of the office visit was not for the recommended preventive service.

In addition to the examples, the regulations specify that: (i) cost-sharing provisions may be applied to preventive services delivered by an out-of-network provider; (ii) a plan may exclude coverage for preventive services prescribed by an out-of-network provider; and (iii) the plan may use reasonable medical management techniques to limit the frequency, method, treatment or setting for preventive services.

The preventive services required by the new regulations generally fall into four categories:

- Evidenced-based items or services with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidenced-informed preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- Evidenced-informed preventive care and screening for women provided for in guidelines supported by the HRSA (to be issued no later than August 1, 2011).

A complete list of recommendations and guidelines related to preventive services that must be covered can be found at <http://www.healthcare.gov/center/regulations/prevention.html>. These recommended preventive services will be updated regularly; however a group health plan is only required to cover preventive services published in the guidelines for plan years beginning on or after the date that is 12 months after the date the new guidelines are published. For example, if a preventive service is added to the published guidelines on September 1, 2011, then a calendar year group health plan would be required to offer coverage and eliminate cost-sharing provisions for these services for the plan year beginning January 1, 2013. In addition, a group health plan will not be required to cover preventive services that are no longer recommended in the published guidelines. It is important to note that group health plans are permitted to provide coverage for preventive items and services in addition to the items published in the guidelines and may subject those services to cost-sharing.

If you have questions regarding the information in this alert, or with respect to other provisions of the health reform legislation as it relates to your employee benefits plans, please contact any of the attorneys in our Employee Benefits Practice Group listed below.

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