DAY PITNEY LLP

alert

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New Guidance Regarding PPACA Preventive Health Care Requirements

Last week, the Departments of Health and Human Services, Labor, and Treasury issued additional guidance regarding the Patient Protection and Affordable Care Act ("PPACA"). This guidance addresses the requirement that group health plans provide certain preventive items and services without cost-sharing. The regulations are effective for plan years beginning on or after September 23, 2010. The regulations do not apply to grandfathered plans. Please see our previous alert regarding grandfathered group health plans at www.daypitney.com/news/newsDetail.aspx?pkID=3213.

The regulations prohibit the imposition of cost-sharing requirements (such as copayments, coinsurance or deductibles) with respect to four broad categories:

- Items or services with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations for routine use as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- 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 can be found at www.HealthCare.gov/center/regulations/prevention.html. The regulations acknowledge that the recommended preventive services may change from time to time. A group health plan is not required to provide coverage after the recommendation or guideline is no longer described by the regulations, and a group plan is required to cover only those preventive services that are recommended at least one year prior to the start of the plan year.

The regulations provide that cost-sharing may be permitted under certain circumstances, including the following:

Related practice areas:

Employee Benefits and Executive Compensation

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- If a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan may impose cost-sharing requirements with respect to the office visit. For example, an individual is screened for cholesterol abnormalities, and the screening has a rating of A or B by the USPSTF. The provider bills the plan for an office visit and for the lab work of the screening test. The plan may not impose any cost-sharing requirements with respect to the screening test, but because the office visit is billed separately from the screening test, the plan may impose cost-sharing requirements for the office visit.
- If a recommended preventive service is not billed separately (or not tracked as individual encounter data 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 requirements with respect to the visit. For example, suppose that, during a child's annual physical exam, the child receives additional services and items that are not recommended preventive services. The provider bills the plan for an office visit. Because the service is billed as part of an office visit rather than as a separate charge, and because the primary purpose of the visit is to deliver recommended preventive services, the plan may not impose a cost-sharing requirement for the office visit.
- 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, then the plan may impose cost-sharing requirements with respect to the visit. For example, an individual visits a provider to discuss abdominal pain and during the visit has a blood pressure screening, which has a rating of A or B by the USPSTF. The provider bills the plan for an office visit. Because the blood pressure screening is provided as part of an office visit for which the primary purpose is not to deliver the recommended preventive service, the plan may impose a cost-sharing requirement for the office visit.
- The regulations do not require a plan that has a network of providers to provide benefits for recommended preventive services that are delivered by an out-of-network provider, nor do the regulations preclude such a plan with a provider network from imposing cost-sharing requirements for recommended preventive services that are delivered by an out-of-network provider.
- A plan may impose cost-sharing requirements for a treatment that is not described above, even if the treatment results from a recommended preventive service.

If you have any questions about the new preventive care requirements or any other matter involving PPACA implementation, please contact a member of the firm's Employee Benefits/Executive Compensation group.