Benefits Alert

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The Patient Protection and Affordable Care Act: New Regulations on Preventive Health Services and Cost Sharing

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The Department of Treasury, Department of Labor, and Department of Health and Human Services ("HHS") have issued another round of regulations relating to the Patient Protection and Affordable Care Act (the "Act"). This time, the regulations relate to preventive health services and cost sharing. Generally, under the Act, group health plans that are not grandfathered plans are required to provide preventive health services without cost-sharing requirements (such as copayments, coinsurance, or deductibles). This requirement is generally effective for plan years beginning on or after September 23, 2010 (for a calendar-year plan, this would be effective January 1, 2011); however, the coverage of an item under a particular guideline is tied to the date the guideline is issued.

General Requirements

Under the Act, a group health plan (and a health insurance issuer offering group or individual health insurance coverage) subject to the preventive care requirements must, at a minimum, provide coverage for, and not impose any cost-sharing requirements for:

- services recommended by the U.S. Preventive Services Task Force;
- immunizations recommended by the Advisory Committee on Immunization Practices of the CDC;
- preventive care and screenings for infants, children and adolescents, supported by the Health Resources and Services Administration ("HRSA"), and
- preventive care and screenings for women supported by HRSA.

It is important to note that the regulations focus on the cost-sharing restriction and do not provide further detail regarding what preventive services are subject to the cost-sharing restriction. However, a current list of recommendations and guidelines that are required to be covered for plan years beginning on or after September 23, 2010 are included in the preamble to the regulation. HHS will post the requirements on its website at the following link: http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

Office Visits

The regulations provide clarification regarding cost-sharing requirements when a recommended preventive service is provided during an office visit. For example, if a recommended preventive service is billed (or tracked) separately from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. However, if the service is not billed (or tracked) separately from an office visit, whether

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cost-sharing requirements can be imposed depends on the primary purpose of the visit. If the primary purpose of the office visit is the delivery of the preventive service, then a plan or issuer may not impose cost-sharing requirements for the visit; however, if not, then a plan or issuer may impose cost-sharing requirements for the visit.

Out-of-Network and Medical Management

The regulations also provide that a plan or issuer does not have to provide coverage for recommended preventive services delivered by an out-of-network provider. Therefore, the plan or issuer may impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider. In addition, if a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for providing the service, the regulations state that a plan or issuer can use reasonable medical management techniques to determine coverage limitations. Using reasonable medical management techniques allows plans and issuers to adapt the recommendations and guidelines to coverage of specific items and services where cost sharing must be waived. Accordingly, the regulations permit a plan or issuer to rely on established techniques and the relevant evidence base to determine the frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.

Effective Date

The regulations provide that coverage must be provided for a plan or policy year beginning on or after the later of September 23, 2010, *or* one year after the date the recommendation or guideline is issued. As a result, recommendations and guidelines issued before September 23, 2009, must be provided for plan years or policy years beginning on or after September 23, 2010. For purposes of the regulations, a recommendation of the Task Force is considered to be issued on the last day of the month on which the Task Force publishes or otherwise releases the recommendation; a recommendation or guideline of the Advisory Committee is considered to be issued on the date on which it is adopted by the Director of the Centers for Disease Control and Prevention; and a recommendation or guideline in the comprehensive guidelines supported by HRSA is considered to be issued on the date on which it is accepted by the Administrator of HRSA or, if applicable, adopted by the Secretary of HHS. Group health plan sponsors and insurers will need to be aware of the changes reflected on the HHS website.

If you have any questions about the regulations or the Act, please contact one of the attorneys in the Employee Benefits & Executive Compensation Group at Bradley Arant Boult Cummings LLP.