



Health Care Reform: Preventive Services

The Patient Protections and Affordable Care Act (PPACA) requires group health plans and insurers to provide preventive health services without cost-sharing. On July 19th, 2010, the Department of Health and Human Services (HHS) published regulations outlining the covered preventive services and cost-sharing requirements. The preventive services requirements apply to non-grandfathered plans beginning at the first renewal after September 23, 2010.

The regulations require that non-grandfathered plans, regardless of whether the plan is self-insured or fully insured, cover preventive services that have strong scientific evidence of their health benefits without any co-payment, co-insurance or deductible when the services are provided by an in-network provider. Plans are not required to provide coverage for the recommended preventive services when the provider is out-of-network. Group health plans and insurers must also comply with any state mandate that provides greater protections to the insured.

Plans that cover preventive services beyond what the new law requires may apply cost-sharing requirements for the additional services.

New recommended services that are included under the law must be covered by a plan beginning with the first plan year that starts one year after the recommendation or guideline under the Public Health Services Act are issued. Since PPACA preventive services requirements take effect for plan years beginning after September 23, 2010, any recommendations and guidelines issued before September 23, 2009 must be provided for that plan year.

Covered Preventive Services

The recommendations that must be included as of the beginning of the plan year after September 23, 2010 can be found in the KTB Library in the Benefits section and include the following:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved.
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the CDC. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the CDC.

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (and not otherwise addressed by the recommendations of the Task Force). HHS expects to issue guidelines no later than August 1, 2011.

Additional information, as well as the full list of preventive services recommendations and guidelines that must be covered can be found at <http://www.healthcare.gov/center/regulations/prevention.html>. This site will be updated as new recommendations and guidelines are released. Plans need only check the site once per year to find any regulations that have been issued or recommended as of the beginning of the previous plan year (for example, a plan that begins January 1, 2011 must include any recommendations or guidelines that were issued before January 1, 2010.)

Cost-Sharing

When the recommended preventive service is provided during an office visit:

- If a recommended preventive service is billed separately (or is tracked separately as individual encounter data) from an office visit, then a plan or issuer may apply cost-sharing requirements with respect to the office visit.
- If a recommended preventive service is not billed separately (or is not tracked separately as individual encounter data) from an office visit and the primary purpose of the office visit is the delivery of such a preventive item or service, then a plan or issuer *may not* apply cost-sharing requirements with respect to the office visit.
- Finally, if a recommended preventive service is not billed separately (or is not tracked separately as individual encounter data) from an office visit and the primary purpose of the office visit is *not* the delivery of such a preventive item or service, then a plan or issuer *may* apply cost-sharing requirements with respect to the office visit.

In response to the Patient Protection and Affordable Care Act and the Health Care and Education Tax Credit Reconciliation Act, collectively known as Health Care Reform, Kistler Tiffany Benefits has formed a Health Care Reform committee to monitor legislation and provide guidance to our valued clients. Our team is creating user-friendly tools and resources, as well as establishing best practices for our clients in regards to the application of this legislation. For more information regarding our services, please contact us at reform@ktbenefits.com.