



# Benefit Trends

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## Health Care Reform – Special Edition

### Health Care Reform: Preventive Health Care Benefits

#### LEGISLATIVE BRIEF

July 16, 2010

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On July 14, 2010, the Departments of Health and Human Services, Labor, and the Internal Revenue Service published the Interim Final Rule on the preventive health care benefits mandate under the Health Care Reform Law (HCR). As you know, non-grandfathered group health plans soon must cover preventive health care services, which have strong scientific evidence of their benefits toward personal health. HCR also requires that participants must have access to these preventive benefits without an out of pocket requirement (co-pays, co-insurance, and deductibles) when delivered by a network provider. The purpose of this Memorandum is to summarize this new Interim Rule.

#### In Brief

The Interim Final Rule calls for plans to provide a range of specific preventive services. The no-cost feature will apply to in-network services; however, the Rule will allow cost-sharing for out of network preventive care services. The Rule also allows a plan to offer other preventive care services not required under HCR and to have cost-sharing requirements for those other services. Finally, if a service is de-listed, plans can delete the service or charge co-pays, etc.

#### Effective Date

Although HCR requires plans to offer preventive care services as of the first day of the plan year beginning on or after September 23, 2010, the law and the Interim Rule also anticipate the development of preventive care recommendations and guidelines. Plans must implement these additional recommendations or guidelines no later than the first plan year beginning on year after their issuance.

#### Mandatory Services

Plans must provide a specific set of preventive care services. Generally, these services include:

- **Evidence-based preventive services:** The U.S. Preventive Services Task Force, an independent panel of scientific experts, rates preventive services based on the strength of the scientific evidence documenting their benefits. Preventive services with a “grade” of A or B, like breast and colon cancer screenings, screening for vitamin deficiencies during pregnancy, screenings for diabetes, high cholesterol and high blood pressure, and tobacco cessation counseling will be covered under these rules.
- **Routine vaccines:** Health plans will cover a set of standard vaccines recommended by the Advisory Committee on Immunization Practices ranging from routine childhood immunizations to periodic tetanus shots for adults.
- **Prevention for children:** Health plans will cover preventive care for children recommended under the *Bright Futures* guidelines, developed by the Health Resources and Services Administration with the American Academy of Pediatrics. These guidelines provide pediatricians and other health care professionals with recommendations on the services they should provide to children from birth to age 21 to keep them healthy and improve their chances of becoming healthy adults. The types of services that will be covered include regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.
- **Prevention for women:** Health plans will cover preventive care provided to women under both the Task Force recommendations and new guidelines being developed by an independent group of experts, including doctors, nurses, and scientists, which are expected to be issued by August 1, 2011.

For a complete list of mandated services, please visit

<http://www.healthcare.gov/center/regulations/prevention.html>

### Administrative Issues

1. **Billing Methodology.** For network services provided during an office visit, and the provider bills separately for the office visit, then the plan may apply cost-sharing to the office visit. If the preventive service is not billed separately and the primary purpose of the office visit is the receipt of the preventive service, then the plan may not apply cost-sharing with respect to the office visit. On the other hand, if the purpose of the office visit was more than just the preventive service, then the plan may apply cost-sharing to the office visit, but not the preventive service. For purposes of capitation plans, the issuer must follow the procedure for tracking the encounter. In other words, if the plan treats the office visit and preventive service as one encounter, then there would be no cost-sharing.
2. **Reasonable Medical Management.** Plans will have flexibility in determining the frequency of services, the method of their delivery or treatment, or the setting for an item or service.
3. **Non-listed Services and Treatment.** Issuers may still cover other preventive care services and may require cost-sharing on those services. Issuers may also limit preventive care services to those required by HCR unless it violates state insurance mandates. The Rule also points out that treatment resulting from preventive services may include cost-sharing requirements.

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