

LEGISLATIVE BRIEF:

NEWS RELATED TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT PREVENTIVE CARE MANDATES FOR NON-GRANDFATHERED PLANS

This document was updated in December 2011. It includes information about requirements relating to women's health benefits issued in August 2011.

Federal agencies recently released a regulation defining how non-grandfathered plans will be required to cover certain preventive care services. The regulation is effective for plan years beginning after September 23, 2010.

Coverage Requirements

The Patient Protection and Affordable Care Act (PPACA) requires non-grandfathered plans, including self-funded plans, to cover defined preventive care services without any cost sharing for the enrollee when provided by in-network providers. The regulation defines preventive care as the following:

- » Evidence-based services that receive an "A" or "B" rating from the U.S. Preventive Services Task Force. These include a number of screenings, certain medication therapies and some behavioral interventions.
- » Immunizations for routine use in all populations as recommended by the Centers for Disease Control and Prevention.
- » Comprehensive guidelines for infants, children, and adolescents as supported by the Health Resources and Services Administration (HRSA). These appear in two charts: the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.
- » Comprehensive guidelines for women supported by the HRSA and developed by the IOM.

Important Considerations

- » Effective dates of the recommendations are important, as plans are not required to cover preventive care services until plan years after the one-year anniversary of the date the recommendation was adopted.
- » For example, the U.S. Preventive Care Task Force approved a recommendation on January 31, 2010, that children age 6 and older be screened for obesity and referred for behavioral interventions. Non-grandfathered plans must cover these services in plan years beginning on or after January 31, 2011. For calendar year plans, that means January 1, 2012.
- » The recommendations of the U.S. Preventive Services Task Force, the CDC and HRSA are subject to changes and additions. As explained above, plans will have at least one year or more to make modifications. Recommendations taken off one of the lists will not have to be covered, although plan change notice requirements may need to be met.
- » Plans that have a network of providers may impose cost sharing for preventive items and services delivered by out-of-network providers. Plans may use reasonable medical management techniques for coverage of preventive items and services to determine the frequency, timing, method, treatment or setting of services to the extent that they are not specified in the relevant recommendation or guideline.
- » HHS is expected to issue further guidance on how plans may offer value based insurance designs around preventive care benefits.
- » If a preventive service is billed separately from an office visit, the plan may impose cost sharing on the office visit. If it is not billed separately from the office visit, then the plan may not impose cost-sharing on the visit if the primary purpose of the visit is to receive the preventive item or service.

If you have questions about your plan's compliance with these requirements or how to implement them, please contact your attorney.

Resources

- » [A comprehensive list of preventive care services required to be covered.](#)
- » [More detailed information on each service required.](#)