



Health Reform Update

Newly Issued Guidance on Preventive Services under PPACA

Late last week interim final rules implementing the Patient Protection and Affordable Care Act (PPACA) requirement that group health plans (both insured and self-insured) cover preventive services without imposing cost-sharing on beneficiaries were jointly released by the IRS, the Employee Benefits Security Administration (EBSA) and the Department of Health and Human Services (HHS). They include a request for comments. The rules are scheduled to be published in the Federal Register on July 19th.

While the rules take effect for group health plan years beginning on or after September 23, 2010, they do not apply to group health plans with grandfathered status.

The rules address such preventive services as mammograms, colonoscopies, cancer screenings, blood pressure and cholesterol testing, counseling to lose weight or quit smoking, and health checkups and immunizations for children. The specific services, as recommended by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics, must be covered without requiring patients to pay deductibles, copayments or coinsurance.

Note that such preventive services must be covered without cost-sharing when they are delivered by network providers, and that health plans are not required to cover preventive services delivered by out-of-network providers. However, plans that do cover out-of-network services are permitted to impose cost-sharing requirements for recommended preventive services that are delivered by an out-of-network provider.

As new preventive services are added to the list of covered services, insurers and health plan providers will have one year to implement those services under these rules.

The new rules also provide some clarification as to when a plan or insurer is allowed to impose cost-sharing requirements, as follows:

- If a preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or insurer may impose cost-sharing requirements with respect to that office visit;

- if a preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is the delivery of such service, then a plan or insurer may not impose cost-sharing requirements with respect to that office visit; and
- if a preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the delivery of such service is not the primary purpose of the office visit, then a plan or insurer may impose cost-sharing requirements with respect to that office visit.

The interim final rules can be found at
<http://www.healthcare.gov/center/regulations/prevention/regs.html>.

Please do not hesitate to contact your **SBA consultant** with any questions.

Our special thanks to Rick Szczebak for his assistance in preparing this update.

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