

Patient Protection and Affordable Care Act of 2010 Coverage of Preventive Services

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, and amended by the Health Care and Education Reconciliation Act (HCERA), signed on March 30, 2010 contains a provision requiring health plans to provide coverage of certain preventive services free from cost sharing requirements. This provision is effective for plan years beginning on or after September 23, 2010 and only applies to non-grandfathered plans/coverage. In this regard, you may want to review AFSCME's fact sheet on grandfathered health plan status available at www.afscme.org/healthcare.

The Departments of Treasury, Labor, and Health and Human Services published interim final rules implementing this provision's requirements on July 19, 2010 in the *Federal Register* and can be viewed here:

<http://www.healthcare.gov/center/regulations/prevention/regs.html> as well as a fact sheet: <http://www.healthcare.gov/law/about/provisions/services/index.html> .

Public comments are being accepted until September 17, 2010, which is the same date the rule goes into effect.

The rule requires the coverage of preventive services without cost sharing in these four categories:

- Evidence-based items or services rated "A" or "B" by the U.S. Preventive Task Force;
- Immunizations for routine use in children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for children as recommended by the Health Resources and Services Administration; and
- Preventive care and screenings for women (not included in the Task Force recommendations) provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Examples of preventive services included in these groups' recommendations include: blood pressure, diabetes, and cholesterol tests; many cancer screenings; routine vaccinations; prenatal care; regular wellness visits for infants and children; counseling on such topics as quitting smoking, losing weight and treating depression. For a list of recommendations and guidelines covered by the Regulations visit

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

Many of the covered preventive services include a recommendation as to frequency, method, treatment or setting for the provision of that service. However, if the guidelines are silent, rules allow the plan to use “reasonable medical management techniques” to determine coverage limitations.

Cost Sharing Guidelines

The rules require first dollar coverage (no cost sharing) for preventive services, but they do not necessarily prohibit cost sharing for office visits relating to those services. The regulations specify that plans cannot impose cost sharing requirements, such as copays, coinsurance or deductibles, with respect to specified preventive services where the preventive services are not billed separately from an office visit if the primary reason for the visit is the receipt of preventive services.

However, cost sharing is permitted for the office visit when:

- a) the office visit and covered preventive services are billed separately; or
- b) the office visit and covered preventive services are not billed separately and the primary purpose of the office visit is *not* delivery of the covered preventive services.

In addition, plans are permitted to impose cost sharing for (or choose not to cover) recommended preventive services if they are provided out-of-network. For preventive services not covered in the recommendations, as well as for preventive services dropped from the recommendations, plans are also permitted to require cost sharing.

Timing for Provision of Coverage of Recommended Preventive Services

The Preventive Services Task Force and other agency recommendations are subject to change. The rules only require plans to cover those preventive services that are recommended at least one year before the start of the plan year. This link to the Task Force’s recommendations includes a “date in effect” column for each recommended service: <http://www.healthcare.gov/center/regulations/prevention/taskforce.html>. For instance, the recommendation on screening and counseling for obesity in children went into effect on January 31, 2010. So, for this service, plans are required to provide coverage without cost sharing in the first plan year that begins on or after January 31, 2011 (January 1, 2012 for calendar year plans).

For further information, contact Steven Kreisberg or Mary Meeker at AFSCME’s Department of Research and Collective Bargaining Services.

July 2010