

## Coverage of Preventive Health Services

**Summary:** Requires all plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the CDC, and certain child preventive services recommended by the Health Resources and Services Administration, without any cost-sharing.

**Status update:** On July 14, the Departments of Health and Human Services (HHS), Labor, and the Treasury released the new regulations. On July 19, those regulations were formally published in the Federal Register.

### Next steps:

- September 19, 2010 -- Comment period closes
- September 30, 2010 – Regulations effective
- August 1, 2011 – Administration expects to complete its recommendations regarding evidence-informed preventive care and screening provided for women

### Additional information:

- Interim Final Regulations released July 14--  
<http://www.healthcare.gov/center/regulations/prevention/regs.html> and  
<http://edocket.access.gpo.gov/2010/2010-17242.htm>
- HHS July 14 press release --  
<http://www.hhs.gov/news/press/2010pres/07/20100714a.html>
- HHS summary -- <http://www.healthcare.gov/law/about/provisions/services/index.html>
- Complete list of recommendations and guidelines that are required to be covered under these interim final regulations -- <http://www.HealthCare.gov/center/regulations/prevention.html>
- U.S. Preventive Health Services Task Force -- <http://www.ahrq.gov/clinic/uspstfix.htm>
- Advisory Committee for Immunization Practices --  
<http://www.cdc.gov/vaccines/recs/acip/default.htm>
- Health Resources and Services Administration (HRSA) Bright Futures recommendations for pediatric preventive care --  
<http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%2020101107.pdf>
- Recommendations from the Secretary's Advisory Committee on Heritable Disorders on Newborns and Children --  
<http://www.hrsa.gov/heritabledisorderscommittee/SACHDNC.pdf>

### Long summary:

**PHS Act sec. 2713. Coverage of Preventive Health Services (as modified by sec. 10101).**

Requires that at a minimum, a group health plan and an issuer offering group or individual coverage provide coverage for and not impose any cost sharing requirements for: (1) evidence-

based items or services that have in effect a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force (USPSTF); (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; (4) with respect to women, such additional preventive care and screening services not described in paragraph (1) above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for this purpose; and (5) for purposes of this Act and for purposes of any other provisions of law, the current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009. States that this provision is not meant to prohibit a plan or issuer from providing coverage for services in addition to those recommended by the USPSTF or from denying coverage for services that are not recommended by the Task Force.

***Interval.*** Requires the Secretary to establish a minimum interval, of no less than 1 year, between the date on which a recommendation or a guideline is issued and the plan year with respect to which the requirement is effective.

***Value-based insurance design.*** The Secretary may develop guidelines to permit a group health plan and an issuer offering group or individual coverage to utilize value-based insurance designs.

### **Summary of the Regulations:**

***Immunizations.*** For immunizations, a recommendation of the Advisory Committee is considered to be “in effect” after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention.

***Preventive care for children.*** Clarified through a separate document that “comprehensive guidelines supported by the Health Resources and Services Administration” includes HRSA’s Bright Futures recommendations as well as recommendations from the Secretary’s Advisory Committee on Heritable Disorders on Newborns and Children.

***Preventive care for women.*** For evidence-informed preventive care and screening for women, the Department of Health and Human Services expects to issue them no later than August 1, 2011.

***Separate billing for office visits.*** The interim final rule (IFR) clarifies the cost-sharing requirements when a recommended preventive service is provided during an office visit. First, if a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. Second, if a recommended 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 an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit. Finally, if a recommended 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 not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. The reference to tracking individual encounter data was included to provide guidance with respect to plans and issuers that use capitation or similar payment arrangements that do not bill individually for items and services.

**Exceptions.** The IFR clarifies that cost-sharing can still be imposed when (1) the recommended preventive services is delivered by an out-of-network provider, (2) for some preventive services if the recommendation or guideline for such services does not specify the frequency, method, treatment, or setting for the provision of that service after the plan or issuer uses reasonable medical management techniques to determine any coverage limitations, and (3) an item or service ceases to be a recommended preventive service, although other provisions may apply.

**Interval.** Sets the interval for implementing the guidelines at one year, the statutory maximum. Coverage must be provided for plan years (in the individual market, policy years) beginning on or after the later of September 23, 2010, or one year after the date the recommendation or guideline is issued. Thus, recommendations and guidelines issued prior to September 23, 2009 must be provided for plan years (in the individual market, policy years) beginning on or after September 23, 2010.

**Value-based insurance design.** The IFR does not address this issue.

### **Legislative text:**

“SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

“(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;

“(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

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

“(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

“(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

“(b) INTERVAL.—

“(1) IN GENERAL.—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

“(2) MINIMUM.—The interval described in paragraph (1) shall not be less than 1 year.

“(c) VALUE-BASED INSURANCE DESIGN.—The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.