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Preventive Care Coverage Guidelines

The Affordable Care Act (ACA) requires non-grandfathered health plans to cover certain preventive health services without imposing cost-sharing requirements for the services. This requirement, which generally became effective for **plan years beginning on or after Sept. 23, 2010**, does not apply to grandfathered health plans. On July 19, 2010, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (the Departments) issued interim final rules relating to coverage of preventive care services.

In August 2011, HHS issued additional preventive care guidelines for women. These additional guidelines, which generally became effective for **plan years beginning on or after Aug. 1, 2012**, require non-grandfathered health plans to cover women's preventive health services (such as well-woman visits, breastfeeding support, domestic violence screening and contraceptives) without charging a copayment, a deductible or coinsurance. Special rules regarding contraceptive coverage apply to religious employers, including churches and other religious-based institutions, such as schools, hospitals, charities and universities.

COVERAGE OF PREVENTIVE CARE SERVICES

For plan years beginning on or after Sept. 23, 2010, non-grandfathered group health plans must cover certain preventive care services and may not charge copayments, coinsurance or deductibles for these services when delivered by a network provider. The recommended preventive care services covered by these requirements are:

- 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;
- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines; and
- For women, evidence-informed preventive care and screening provided in guidelines supported by HRSA (for plan years beginning on or after Aug. 1, 2012).

A list of recommended preventive services is available at: www.healthcare.gov/what-are-my-preventive-care-benefits.

Office Visits

The interim final rules clarify the cost-sharing requirements when a recommended preventive care service is provided during an office visit. Whether cost-sharing requirements may be imposed will depend on:

- Whether the preventive care service is billed or tracked separately; and
- Whether the preventive care service is the primary purpose of the office visit.

Cost-sharing is permitted only if:

- The recommended preventive care service is billed separately (or is tracked as individual encounter data separately) from an office visit; or

- The recommended preventive care service is not billed separately from the office visit and the primary purpose of the office visit is not to obtain the recommended preventive care service.

Cost-sharing requirements are not allowed in cases where the recommended preventive care service is not billed separately, but it is the primary purpose of the office visit.

EXAMPLES

Example 1—An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is given a cholesterol screening (a recommended preventive care service). The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test. The plan may not impose any cost-sharing requirements with respect to the laboratory work. Because the office visit is billed separately from the cholesterol test, the plan may impose cost-sharing requirements for the office visit.

Example 2—An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening (a recommended preventive care service). The provider bills the plan for an office visit. The blood pressure screening was not the primary purpose of the visit. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 3—A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam (a recommended preventive care service). During the office visit, the child receives additional items and services that are not recommended preventive services. The provider bills the plan for an office visit. The recommended preventive care service was not billed as a separate charge and was the primary purpose of the visit. Therefore, the plan may not impose a cost-sharing requirement for the office visit.

Additional Clarifications

The interim final rules make clear that plans may continue to impose cost-sharing requirements on preventive care services that employees receive from out-of-network providers. Also, plans may use reasonable medical management techniques to determine the frequency, method, treatment or setting for preventive care services, as long as they are not specified in the recommendation or guideline.

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. An FAQ issued on May 2, 2014, clarifies what are plans and issuers expected to provide as preventive coverage for tobacco cessation interventions. According to the Departments, evidence-based clinical practice guidelines can provide useful guidance for plans and issuers. The Departments will consider a group health plan or health insurance issuer to be in compliance with the requirement to cover tobacco use counseling and interventions, if, for example, the plan or issuer covers, without cost-sharing:

- Screening for tobacco use; and
- For those who use tobacco products, at least **two tobacco cessation attempts** per year. For this purpose, covering a cessation attempt includes coverage for:
    - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
    - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen, when prescribed by a health care provider, without prior authorization.

This guidance is based on the Public Health Service-sponsored Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update.

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WOMEN'S PREVENTIVE CARE SERVICES

On Aug. 1, 2011, HHS issued the HRSA-supported preventive care guidelines for women to fill the gaps in the current preventive health services guidelines for women. According to HHS, these guidelines help ensure that women receive a comprehensive set of preventive health services without having to pay a copayment, a deductible or coinsurance.

Non-grandfathered health plans were required to cover these services without cost-sharing for **plan years beginning on or after Aug. 1, 2012 (Jan. 1, 2013, for calendar year plans)**, subject to the special provisions described below for religious employers. The list of recommended preventive services for women is available through HHS at: www.healthcare.gov/what-are-my-preventive-care-benefits.

According to HHS, health plans may use reasonable medical management techniques for women's preventive care to help define the nature of the covered service, consistent with guidance provided in the interim final rules. For example, health plans may control costs and promote efficient delivery of care by continuing to charge cost-sharing for brand-name drugs if a safe and effective generic version is available. In addition, the interim final rules confirmed that plans may continue to impose cost-sharing requirements on preventive services that employees receive from out-of-network providers.

CONTRACEPTIVE COVERAGE AND RELIGIOUS EMPLOYERS

The preventive care guidelines for women include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity. The Departments have provided special contraceptive coverage rules for nonprofit religious employers and organizations. These rules exempt churches and other houses of worship from the ACA's requirement to cover contraceptives. For other church-affiliated institutions that object to contraceptive coverage, such as schools, charities, hospitals and universities, these rules establish a temporary enforcement delay and an accommodations approach.

Exemption for Churches

In 2011, the Departments provided an exemption from the ACA's contraceptive coverage requirement for **group health plans of certain nonprofit religious employers** (such as churches and other houses of worship). Under this exemption, eligible employers offering health coverage may decide whether or not to cover contraceptive services, consistent with their beliefs. A "religious employer" was defined as an employer that:

- Has the inculcation of religious values as its purpose;
- Primarily employs persons who share its religious beliefs; and
- Primarily serves persons who share its religious beliefs.

On July 2, 2013, the Departments published a final rule that simplifies the definition of a "religious employer" as it relates to the contraceptive coverage exemption, effective for plan years beginning on or after Jan. 1, 2013. Under the simplified definition, a religious employer will qualify for the exemption to the contraceptive coverage mandate if it is a nonprofit entity that is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code. This definition primarily includes churches, other houses of worship and their affiliated organizations.

The simplified definition is intended to clarify that a house of worship is not excluded from the exemption because, for example, it provides charitable social services to, or employs, persons of different religious faiths.

Temporary Safe Harbor

HHS established a temporary enforcement safe harbor for nonprofit organizations that do not provide some or all of the required contraceptive coverage based on their religious beliefs. The enforcement safe harbor is effective for **plan**

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years beginning before Jan. 1, 2014. For plan years beginning on or after Jan. 1, 2014, the accommodations approach described below is effective.

Under the terms of the safe harbor, the Departments will not take any enforcement action against employers, group health plans or group health issuers that meet the eligibility criteria for the safe harbor and that fail to cover some or all of the recommended contraceptive services without cost sharing. This safe harbor covers church-affiliated organizations that do not qualify for the exception for non-profit religious employers, such schools, hospitals, charities and universities.

Accommodations Approach

The June 2013 final rule provides accommodations for nonprofit religious organizations that object to contraceptive coverage on religious grounds and do not qualify for the church exemption. The accommodations are effective for **plan years beginning on or after Jan. 1, 2014.** The temporary safe harbor applies until then.

An eligible organization is one that:

- Opposes providing coverage for some or all of any contraceptive services which are required to be covered on account of religious objections;
- Is organized and operates as a nonprofit entity;
- Holds itself out as a religious organization; and
- Self-certifies that it meets these criteria.

Under the accommodations, eligible organizations do not have to contract, arrange, pay or refer for any contraceptive coverage to which they object on religious grounds. However, separate payments for contraceptive services will be provided to females in the health plan by an independent third party, such as an insurance company or third-party administrator (TPA), directly and free of charge.

The Departments also proposed rules for religious non-profit organizations that are institutions of higher education. If this type of organization arranges for student health insurance coverage, it is eligible for an accommodation comparable to the type available for a religious organization with an insured group health plan.

On June 30, 2014, in *Burwell v. Hobby Lobby Stores, Inc. et al*., the U.S. Supreme Court created a narrow exception to the contraceptive mandate for closely held for-profit businesses that object to providing coverage for certain types of contraceptives based on their sincere religious beliefs. In light of the Supreme Court's decision, the Departments issued a proposed rule on Aug. 27, 2014, that would amend the definition of an "eligible organization" for purposes of the accommodations approach under the July 2013 final rule. The amended definition would include a **closely held for-profit entity that has a religious objection** to providing coverage for some or all of the contraceptive services otherwise required to be covered. This proposed change would extend the accommodations approach available for non-profit entities to group health plans established or maintained by certain closely held for-profit entities with similar religious objections to contraceptive coverage.

Thus, under the proposed rules, a qualifying closely held for-profit entity would not be required to contract, arrange, pay or refer for contraceptive coverage. Instead, payments for contraceptive services provided to participants and beneficiaries in the eligible organization's plan would be provided or arranged separately by an issuer or a TPA.

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