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Health Care Reform Act Update – Guidance Issued on Preventive Services

On July 14, 2010, the Departments of Health and Human Services ("HHS"), in conjunction with the Department of Labor ("DOL") and the Treasury Department, issued interim final rules for group health plans and health insurance issuers relating to coverage of preventive services under the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Health Care Reform Act"). These regulations provide guidance regarding the Health Care Reform Act requirement that group health plans, both insured and self-insured, must cover certain evidence-based preventive services and eliminate the participant cost-sharing requirements for such services.

Task Force to Recommend Preventive Services. Recommended preventive services will be identified in guidelines and recommendations developed by various agencies, including the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. The current preventive services guidelines and recommendations are set forth in the regulations. HHS will also periodically publish new guidelines and recommendations, and plans will then be required to comply with any new guidelines and recommendations as of the plan year beginning on or after the one-year anniversary of the date the guidelines or recommendations are issued. For certain guidelines and recommendations that went into effect after September 23, 2009, relevant compliance dates and additional information are available on the HHS website at:

www.healthcare.gov/center/regulations/prevention/recommendations.html.

Cost-Sharing Requirements. These rules provide guidance on the application of participant cost-sharing requirements to preventive services that are offered during an office visit. In general, if preventive services are billed separately, or if the primary purpose of the office visit is not to deliver preventive care, a plan may impose cost-sharing requirements.

Payment of Preventive Services Delivered by an Out-of-Network Provider. Plans are not required to cover preventive services provided by an out-of-network provider. However, if preventive services are covered, a plan may impose cost-sharing requirements.

Effective Date. Plans will be required to comply with the guidelines and recommendations listed in the regulations as of the first day of the plan year beginning after September 23, 2010. Grandfathered health plans are not required to comply with these interim final rules.

Employers should begin working now to comply with these regulations. Please contact one of the individuals listed below, or the Reed Smith attorney with whom you regularly work, to learn more about these regulations on preventive services under the Health Care Reform Act.

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