

Healthcare Reform and Preventive Health

Preventive Services

The Patient Protection and Affordable Care Act, or healthcare reform, introduced changes to how many self-insured health plans cover preventive services. The legislation's provisions on preventive health coverage affect non-grandfathered health plans (those that began providing coverage after March 23, 2010, or made plan changes triggering the loss of grandfathered status) during plan years beginning on or after Sept. 23, 2010.

Under the new law, health plans must provide 100 percent coverage for certain preventive services and immunizations provided by a network doctor or hospital. Cost-sharing requirements, such as copayments, deductibles or coinsurance, are prohibited for preventive health provided by a network healthcare provider. However, health plans are not required to provide coverage for preventive services from non-network hospitals and doctors, and they may impose a cost-sharing requirement when the services are provided out of network.

Covered Preventive Services and Immunizations

With healthcare reform, health plans cannot impose any cost-sharing requirements for the following preventive services and immunizations:

- Grade A and B recommendations of the U.S. Preventive Services Task Force, including mammographies for women older than 40 every one to two years, colonoscopies for adults beginning at age 50, and screenings for high blood pressure and cholesterol abnormalities
- Additional preventive care and screenings for women contained in comprehensive guidelines supported by the U.S. Health Resources and Services Administration (The U.S. Department of Health and Human Services expects to issue these guidelines by Aug. 1, 2010.)
- Immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings for infants, children and adolescents contained in comprehensive guidelines supported by the U.S. Health Resources and Services Administration (Guidelines call for regular monitoring of measurements, vision and hearing screenings, screenings for certain abnormalities and developmental/behavioral assessments.)

For an up-to-date list of preventive health services and immunizations for which health plans must provide 100 percent coverage, please visit www.coresource.com and follow the link from the Healthcare Reform button located on the home page.

Other Considerations

- A plan is not required to provide coverage for a particular preventive service until the plan year that begins one year after the date the recommendation or guideline was issued.
- A health plan may use reasonable medical management approaches to determine the appropriate frequency, method or setting for a preventive service if it is not specified in guidelines or recommendations.

Office Visits

- If an office visit is billed separately from the preventive service, then the plan may impose a cost-sharing requirement on the office visit.
- If a preventive service is not billed separately from an office visit, and the primary purpose of the office visit is the delivery of the preventive service, then no cost-sharing requirements may be applied to the office visit.
- If the preventive service is not billed separately from the office visit, but the primary purpose of the office visit was for something other than the delivery of the preventive service, then the plan may impose a cost-sharing requirement on the office visit.



Our Commitment: Keeping You Informed!

CoreSource is committed to keeping you up to date on healthcare reform and how provisions affect your health plan, as information becomes available. For more information, visit www.coresource.com and follow the link on healthcare reform from the home page.

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