



**DATE:** August 19, 2011  
**TO:** Our Valued Client Partners & Friends  
**FROM:** HIB Account Team  
**RE:** **LEGISLATIVE UPDATE 2011-7:  
Interim Final Rule: Women's Preventive Care Services**

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We are pleased to bring you our **Legislative Update 2011-7: Interim Final Rule: Women's Preventive Care Services**. This memorandum provides an update on some recent updates to preventive care services pertaining to women. As always, please feel free to contact your HIB Account Team for assistance.

## INTERIM FINAL RULE: WOMEN'S PREVENTIVE CARE SERVICES

### WHY ARE WE HERE?

As you may recall, the Patient Protection and Affordable Care Act (PPACA) requires all non-grandfathered group health plans, whether insured or self-insured, to provide a panoply of preventive care services to all plan participants, including Medicare-eligible individuals. On July 19, 2010, the three agencies in charge of producing regulations (Departments of Treasury, Labor, and Health and Human Services), referred to as "The Agencies" in these Memoranda produced an [Interim Final Regulation](#), implementing the preventive care provisions effective for plan years beginning on or after September 23, 2010. Only grandfathered group health plans remain exempt from the preventive care mandate.

On August 1, 2011, The Agencies issued an [Amendment](#) to the original Interim Rule on preventive care, specifically on services applicable to women, derived from comments generated by the request for comments at the issuance of the July 2010 Interim Final Rule, as well as the rules generated by the Health Resources and Services Administration (HRSA), an Agency within HHS.

### IN A NUTSHELL

For plan years beginning on or after August 1, 2012 (e.g. January 1, 2013 for calendar year group health plans), non-grandfathered plans must provide the following services, in addition to those required by the initial Interim Rules published on July 19, 2010 (see below):

- i Annual well-women visits to obtain age and developmentally appropriate preventive services, including preconception and prenatal care and other preventive services;
- i All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, although group health plans sponsored by certain religious employers are exempt from this requirement (also discussed below);
- i Screening for gestational diabetes in pregnant women;
- i Human papillomavirus testing, beginning at age 30 and no more frequently than every 3 years thereafter;
- i Annual counseling for sexually transmitted infections;



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- i Annual counseling and screening for human immunodeficiency virus (HIV);
- i Breastfeeding support, supplies and counseling in connection with each birth; and
- i Annual screening and counseling for interpersonal and domestic violence.

**RELIGIOUS EXEMPTION**

A key part of this Amendment is the granting of an exemption to certain "religious employers" with regard to contraceptive services. A "religious employer" is one that:

- i Has the inculcation of religious values as its purpose;
- i Primarily employs persons who share its religious tenets;
- i Primarily serves persons who share its religious tenets; and
- i Is a non-profit organization under Section 6033(a)(1) and Section 6033(a)(3)(A)(i) or (iii) of the Code.

Sections 6033(a)(3)(A)(i) and (iii) refer to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order.

**STATE LAWS**

Most states require insured group health plans to provide coverage for specific preventive services. The PPACA rules for preventive services remain separate from those laws. Insurers of non-grandfathered group health plans must meet the state law requirements in addition to the PPACA preventive care rules to the extent that a state law is more strict. Some states also have enacted a religious employer exemption from coverage for contraceptive coverage. Insurers in those states must follow the stricter rule.

**MEDICARE**

PPACA also contains preventive care requirements applicable to those enrolled in Medicare as well as Medicare Advantage and Medicare Supplement Plans.

**OVERVIEW OF THE PREVENTIVE CARE MANDATE**

PPACA requires group health plans to provide a range of specific preventive services at no cost to the plan participant. The no-cost feature will apply to in-network services; however, the Rule will allow cost-sharing for out of network preventive care services. The Rule also allows a plan to offer other preventive care services not required under HCR and to have cost-sharing requirements for those other services. Finally, if a service is de-listed, plans can delete the service or charge co-pays, etc.

**Mandatory Services.** Plans must provide a specific set of preventive care services. Generally, these services include:

- i **Evidence-based preventive services:** The U.S. Preventive Services Task Force, an independent panel of scientific experts, rates preventive services based on the strength of the scientific evidence documenting their benefits. Preventive services with a "grade" of A or B, like breast and colon cancer screenings, screening for vitamin deficiencies during pregnancy, screenings for diabetes, high cholesterol and high blood pressure, and tobacco cessation counseling will be covered under these rules.



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- i **Routine vaccines:** Health plans must cover a set of standard vaccines recommended by the Advisory Committee on Immunization Practices ranging from routine childhood immunizations to periodic tetanus shots for adults.
- i **Prevention for children:** Health plans will cover preventive care for children recommended under the *Bright Futures* guidelines, developed by the Health Resources and Services Administration with the American Academy of Pediatrics. These guidelines provide pediatricians and other health care professionals with recommendations on the services they should provide to children from birth to age 21 to keep them healthy and improve their chances of becoming healthy adults. The types of services that will be covered include regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.
- i **Prevention for women:** Health plans will cover preventive care provided to women under both the Task Force recommendations and the [HSRA guidelines](#) published on August 1, 2011 in conjunction with the Amendment.

**Billing Issues: Office Visits.** For network services provided during an office visit, and the provider bills separately for the office visit, then the plan may apply cost-sharing to the office visit. If the preventive service is not billed separately and the primary purpose of the office visit is the receipt of the preventive service, then the plan may not apply cost-sharing with respect to the office visit. On the other hand, if the purpose of the office visit was more than just the preventive service, then the plan may apply cost-sharing to the office visit, but not the preventive service. For purposes of capitation plans, the issuer must follow the procedure for tracking the encounter. In other words, if the plan treats the office visit and preventive service as one encounter, then there would be no cost-sharing.

We will provide more information on preventive care issues as it becomes available.

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