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BULLETIN
Docket No.: INS-16-018-AB

TO: All New Hampshire Licensed Health Carriers

FROM: Roger A. Sevigny

DATE: April 1, 2016

RE: Coverage of Preventive Health Services under the Patient Protection and Affordable Care Act

I. Introduction

The purpose of this Bulletin is to address issues relative to required coverage of preventive health services under 42 U.S.C. § 300gg-13, 45 CFR § 147.130 and 29 CFR § 2590.715-2713.

II. Legal Authority

The New Hampshire Insurance Commissioner "is charged with the rights, powers, and duties pertaining to the enforcement and execution of the insurance laws" of New Hampshire. NH RSA 400-A:3. Specifically, the Commissioner has the authority to "[e]nforce the consumer protections and market reforms set forth in the (Patient Protection and Affordable Care) Act that relate to insurance." NH RSA 420-N:5. This authority extends to regulations adopted by the Centers for Medicare and Medicaid Services (CMS) under the Act. See RSA 420-N:2, I (defining "Act" to include federal regulations).

III. Required Coverage of Preventive Health Services

Pursuant to 42 U.S.C. § 300gg–13 and codifying regulations, non-grandfathered group and individual health plans must provide coverage for all "preventive health" items and services and may not subject such items or services to cost-sharing (including copayment, coinsurance or deductible). The preventive health items and services subject to this requirement are:

- Evidence-based items or services with a rating of "A" or "B "with respect to the individual involved in the current United States Preventive Services Task Force (USPSTF) recommendations;

- Immunizations for routine use in children, adolescents, and adults that have in effect an Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) recommendation with respect to the individual involved;
- Evidence-informed preventive care and screenings for infants, children, and adolescents provided for by the Health Resources and Services Administration (HRSA) comprehensive guidelines; and
- Any evidence-informed preventive care and screenings for women not already provided for but included in binding comprehensive health plan coverage guidelines supported by HRSA.

Federal law specifies that carriers must adhere to the *current* versions of the guidelines listed above. 45 CFR §147.130(b). Carriers need not make immediate changes to coverage and cost-sharing requirements when recommendations or guidelines change, but must make conforming changes for plan or policy years beginning on or after one year following the effective date of the new recommendations or guidelines.[1] Conversely, coverage without cost-sharing for preventive care items or services must be maintained – based on the applicable recommendations and guidelines on the first day of the plan or policy year - through the last day of the plan or policy year even if the recommendation or guidelines change during the plan or policy year.[2] 45 CFR §147.130(b).

To the extent a recommendation or guideline does not specify frequency, method, treatment or setting for delivery of the item or service, the carrier may apply reasonable medical management standards in determining coverage and cost-sharing. 45 CFR §147.130(a)(4).

IV. Coverage of Diagnostics and Treatment Resulting from Preventative Procedures

The cost of treatment that results from, but is not part of, a preventative procedure may be subject to cost-sharing as long as that treatment is not itself included in the recommendations and guidelines outlined above. 45 CFR § 147.130(a)(2)(iv). The Federal regulations give the example that hyperlipidemia medication prescribed as a result of a diagnosis following a screening may be subject to cost-sharing because the medication is not, itself, a preventive health service. However, CMS has clarified that a treatment that is considered an integral part of a preventive service (such as polyp removal during colonoscopy) may not be subject to cost-sharing.[3]

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[1] The preamble to the regulation states that a recommendation or guideline of the USPSTF is considered to be issued on the last day of the month on which the Task Force publishes or otherwise releases the recommendation; a recommendation or guideline of the Advisory Committee is considered to be issued on the date on which it is adopted by the Director of the Centers for Disease Control and Prevention; and a recommendation or guideline in the comprehensive guidelines supported by HRSA is considered to be issued on the date on which it is accepted by the Administrator of HRSA or, if applicable, adopted by the Secretary of HHS. 75 FR 41729.

[2] This requirement does not apply to the extent the USPSTF downgrades the item or service to a D rating or any item or service is subject to a safety recall or otherwise determined by the Federal regulatory body of jurisdiction to pose a significant safety concern.

[3] See CMS's Affordable Care Act FAQ #12, response to Q5, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

V. Post-Treatment Preventive Care

The fact that a preventive screening is recommended because of an individual's family or personal history does not mean the screening may be subject to cost-sharing. Certain guidelines and recommendations are specific to high-risk populations and CMS has clarified that it is up to the provider to determine if a person is considered "high risk."[4] This may include individuals who require follow-up screening after completing a regimen of treatment. Once that regimen of treatment is complete, the individual shall be treated as receiving preventive care for any screenings that are rated as "A" or "B" by the USPSTF for the high risk population to which his or her physician has assigned the patient.[5]

This also applies to other preventive health recommendations and guidelines that are specific to individuals' personal or family history.

VI. Enrollees' Expectations of Preventive Health Services Provided In-Network

Enrollees have a reasonable expectation that preventive health items and services delivered in-network adhere to the carrier's medical management standards, and will be covered at no cost to the enrollee. While federal regulations provide that carriers may apply reasonable medical management standards to preventive health services,[6] limitations on coverage of these services at in-network providers are not valid if they are not clearly conveyed to enrollees in advance. Likewise, carriers can apply cost-sharing requirements that are part of value-based insurance designs, such as requirements based on point of service rules,[7] but only if the requirements have been adequately communicated to enrollees.

Failure to notify enrollees in advance that a procedure that is commonly understood to be a preventive service (e.g., an annual mammogram) will not be covered if performed at a particular in-network provider, with the use of certain technology, or at a specific location, may be a deceptive practice under RSA 417:4, I and/or XV.

Carriers are expected to notify providers of their medical management standards during the network-building and provider-contracting process to ensure that the provision of preventive services by their network providers will adhere to those standards. If such agreement cannot be reached, the carrier should not contract with the provider for preventive health items or services and must provide appropriate notice to enrollees in its network adequacy submission and network directory that specific items or services delivered by the in-network provider are not covered.

VII. Contact Information

Questions related to this bulletin should be directed to Jennifer Patterson, Health Policy Legal Counsel, at (603) 271-2261, ext. 215 or by email: jennifer.patterson@ins.nh.gov or to Michael Wilkey, Director Life, Accident and Health, at (603)271-2261, ext. 330 or by email: michael.wilkey@ins.nh.gov.

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[4] See CMS's Affordable Care Act FAQ #12, response to Q7, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

[5] Id.

[6] 45 CFR 147.130(1)(a)(4).

[7] http://www.dol.gov/ebsa/faqs/faq-aca5.html