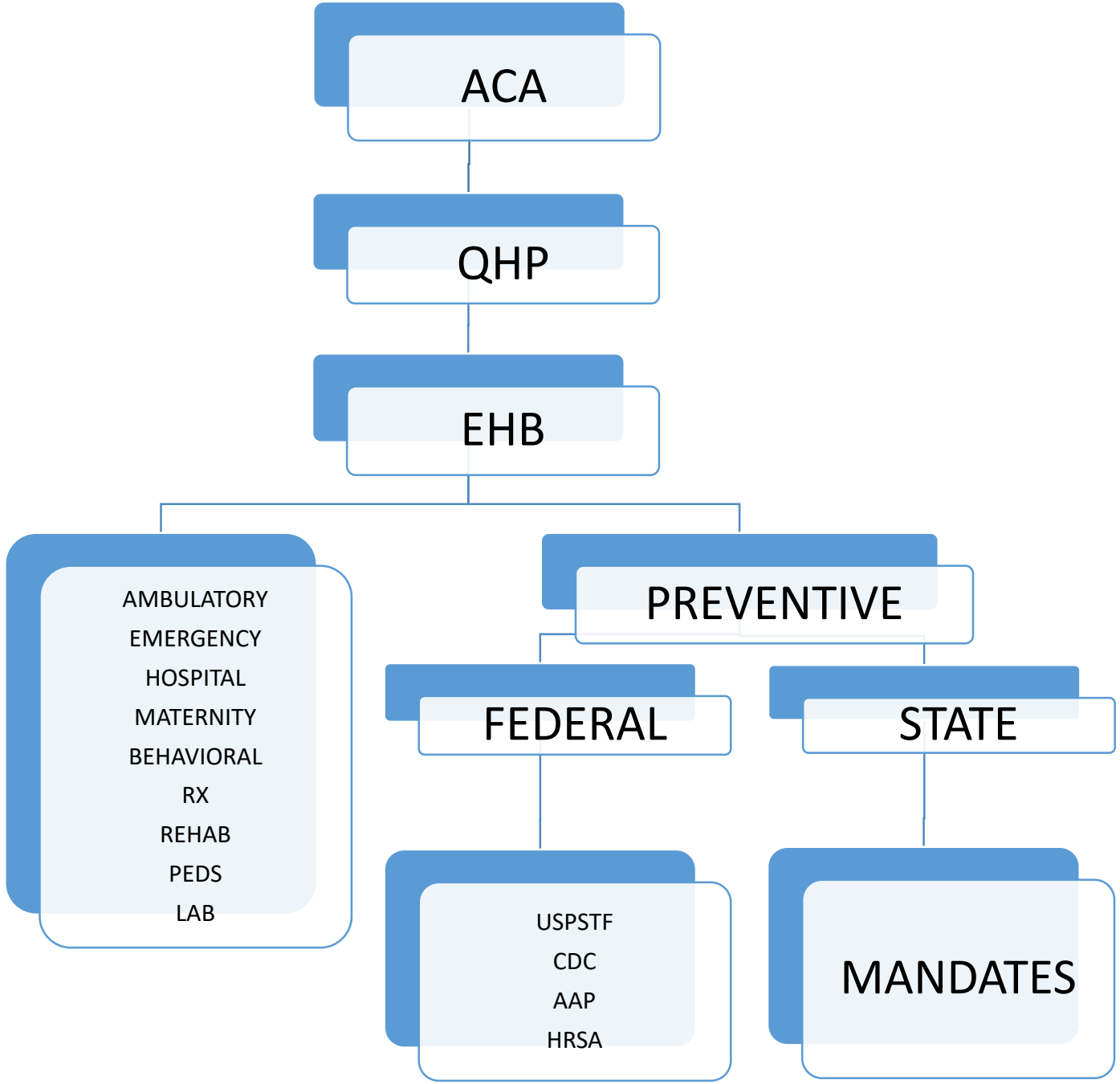
Preventive Health Care Benefits

Preventive Grant Provisions

- Health Insurance Enforcement and Consumer Protections Grant Program also know as “Preventive Grant”
  - Market Conduct review of group and individual health insurance markets to ensure benefits under the Affordable Care Act are being processed accurately.
  - The primary focus of the review is on Section 2713 of the ACA related to the coverage of preventive benefits.
  - Application of lessons learned to educate consumers providers and insurers.

Goals

- Collaboration to facilitate greater use of preventive services by minimizing the billing issues or uncertainty that may dissuade individuals from seeking preventive services.
- Improve health outcomes for citizens across the Commonwealth.
- Improve provider relationships with insurers.
- Decrease health care expenditures and claims costs.


ACA
QHP
EHB
AMBULATORY
EMERGENCY
HOSPITAL
MATERNITY
BEHAVIORAL
RX
REHAB
PEDS
LAB
PREVENTIVE
FEDERAL
STATE
USPSTF
CDC
AAP
HRSA
MANDATES

It is important to remember that not all insurance plans fall under the jurisdiction of the Kentucky Department of Insurance.

Health Benefit Plans

Self-funded Health Benefit Plan

- Health insurance plan in which the sponsoring organization (usually the employer) assumes the financial risk for paying for covered services provided to its enrollees (Examples: Ford or GE).
- This means the employer or group sets aside funds and employee premiums each month to pay health claims submitted to the plan.
- Self-funded plans are under the authority of the U.S. Department of Labor's Pension and Welfare Benefits Administration. These plans are authorized by Congress under the Employee Retirement Income Security Act (ERISA).

Fully-funded Health Benefit Plan

- Individual, small and large group health insurance plans in which the insurer assumes the financial risk of paying for covered services.
- The Kentucky Department of Insurance regulates these plans.
- Not sure if the plan is self-funded or fully funded?
- Patients can ask their employer or the plan administrator (ex: Anthem, Humana). Office staff/patient could also call the phone number on the insurance card

Exchange Plans Must be Qualified Health Plans

- Benchmark plans,
- Based on requirements related to marketing, choice of providers, plan networks, **essential health benefits** and other features,
- Reviewed by the Kentucky Department of Insurance for compliance,
- May be sold off the exchange,
- May receive Cost Share Reduction (CSR) subsidy and/or Advance Premium Tax Credit (APTC).

Different Levels of Plans

- Bronze, silver, gold and platinum—depending upon the services the consumer prefers and cost sharing determined by the actuarial value of the coverage compared to the actuarial value of the “essential health benefits.” Health insurers must offer silver and gold plans in the exchange.
- Essential Health Benefits are the same on all levels of plans

Federal Oversight

- HealthCare.gov provides federal subsidies for qualified health plans for people with incomes between 133 percent and 400 percent of federal poverty guidelines in the form of a premium credit.

- HealthCare.gov screens enrollees for eligibility in health and human services programs, such as Medicaid and Marketplace.

- CSR subsidies lower out-of-pocket cost sharing amounts on Health Insurance Marketplace Silver plans for those making between 100% - 250% of the Federal Poverty Level in household income. These pair with APTC which lower premium costs for those making between 100% – 400% of the poverty level.

Essential Health Benefits

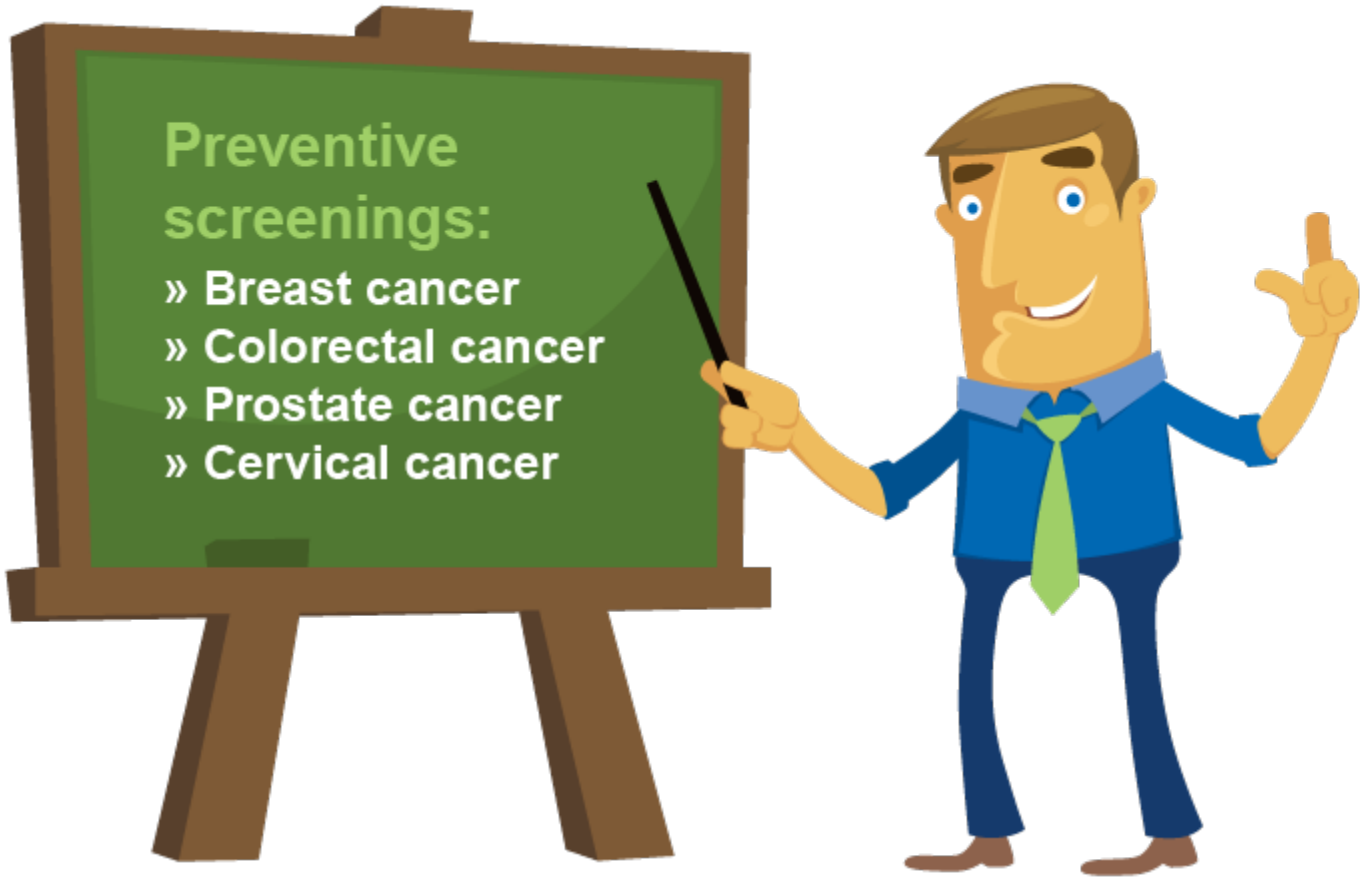
- The Affordable Care Act requires that all non-grandfathered individual and small group health insurance plans sold in a state, including those offered through an Exchange, cover certain essential health benefits.
- Exempt from the EHB requirement are large-group health plans, self-insured ERISA plans, and ERISA-governed multiemployer welfare arrangements not subject to state insurance law.

Essential Health Benefits (EHBs) include items and services in the following ten benefit categories:

(1) ambulatory patient services;
(2) emergency services;
(3) hospitalization;
(4) maternity and newborn care;
(5) mental health and substance use disorder services including behavioral health treatment;
(6) prescription drugs;
(7) rehabilitative and habilitative services and devices;
(8) laboratory services;
(9) preventive and wellness services and chronic disease management; and
(10) pediatric services, including oral and vision care

Preventive Care
An Essential Health Benefit

- Why?
  - Chronic disease (heart disease, cancer, stroke, diabetes, etc.) responsible for 7 of 10 deaths and 75% of nation's health spending.
  - Preventive medicine can help with early detection, reformation of life habits, and possible prevention of many of these conditions:
    - 80% of type 2 diabetes
    - 40% of cancer.
  - Reduction of costs
  - Improvement of health outcome


Preventive screenings:
» Breast cancer
» Colorectal cancer
» Prostate cancer
» Cervical cancer

Coverage of preventive health services 29 CFR § 2590.715-2713

A Health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for and must not impose any cost-sharing requirements for:

- 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 have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; including American Academy of Pediatrics and Bright Futures
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Section 2713 of ACA

Requires non-grandfathered group and individual health plans to provide coverage of preventive health services without cost-sharing. This includes plans available through the Health Insurance Marketplace.

IMPORTANT

Preventive services are free and not subject to cost sharing only when delivered by a doctor or other provider in your plan's network


If I win the lottery, the first thing I'll do is meet my deductible.
someecards

KY Preventive Legislation or Statute

- KRS 304.17A-168 effective June 29, 2017 Coverage for tobacco cessation and services
- KRS 304.17A-257 effective January 1, 2016 Colorectal cancer examination and laboratory test.
- 19RS SB 30 signed into legislation March 3, 2019 effective January 1, 2020 new subtitle in subtitle 17A chapter 304 is an Act relating to cancer prevention coverage for screening and appropriate genetic test.

Prevention of Tobacco Use in Adults

ACA

A health plan or a health insurer must provide coverage for all forms of tobacco cessation services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF)

- Not impose any cost-sharing requirements
- The USPSTF recommends that clinicians ask all adults about tobacco use, counsel and provide behavioral interventions and Food and Drug Administration approved pharmacotherapy for cessation to adults who use tobacco.
- May utilize medical management for attempt limits and limit medication to one in each classification.
- Need Rx from Provider

Kentucky Health Benefit Plan

- Provide coverage for all FDA-approved tobacco cessation medications, all forms of tobacco cessation services recommended by USPST including to individual, group, and telephone counseling, and any combination thereof.
- Cannot impose, counseling requirements for medication; limits on the duration of services (annual or lifetime limits on the # of attempts to quit; or any cost-sharing including copayments or deductibles.
- May utilize medical management for more than two attempts a year and require approval.
- Need Rx from Provider.

Colon Cancer Screening

ACA

- Recommended by the USPTF with a rating of A or B at age 50-75 years.
- Positive result from a screening FIT or stool DNA follow up colonoscopy may not be considered screening.
- May have lab cost
- Screening for high risk patients may differ with plans.
- In network providers
- Not impose any cost-sharing.

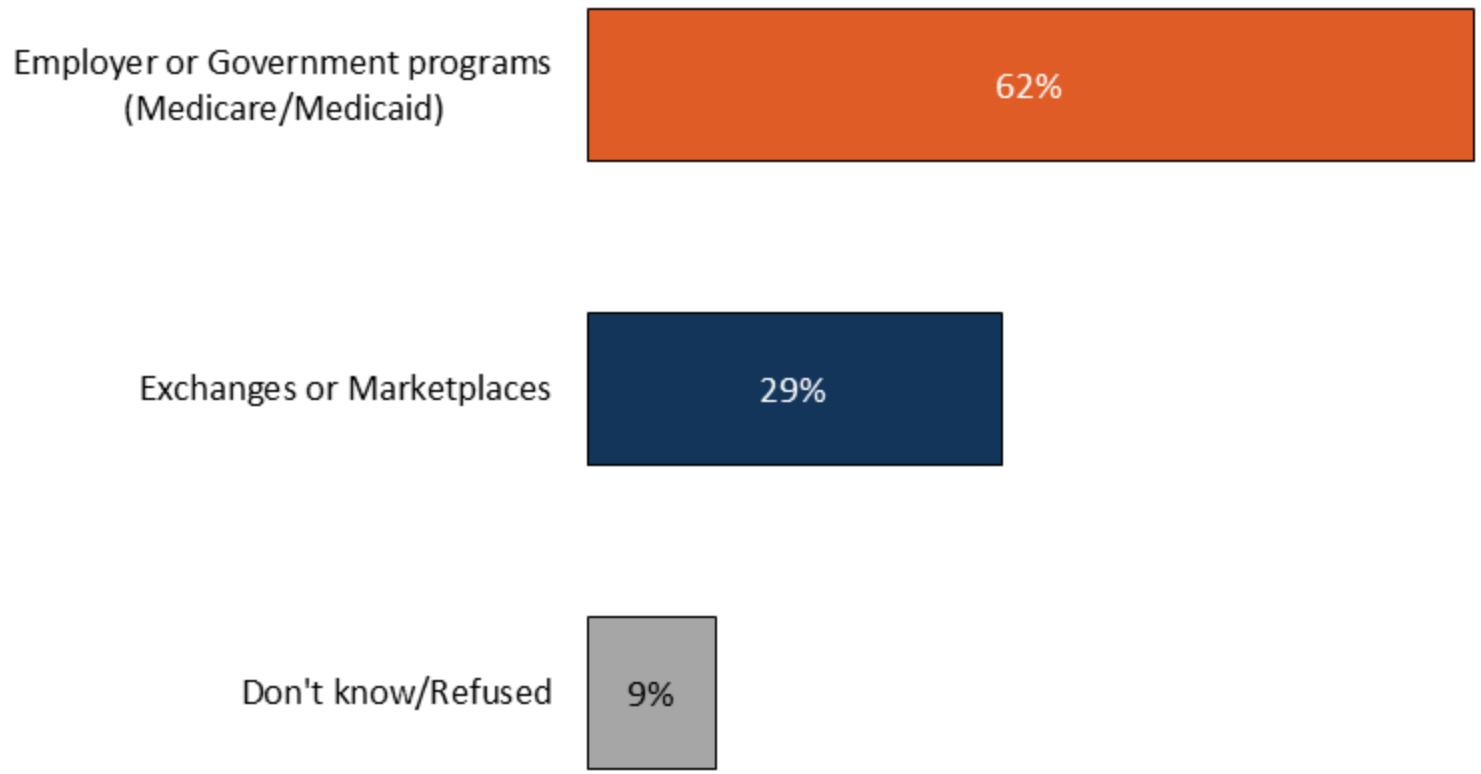
Fully Funded KY Health Benefit Plan

- Recommended Current American Cancer Society Guidelines at age 45 for average risk and also high risk guidelines
- Positive result from a screening FIT or stool DNA follow up colonoscopy should be considered a screening.
- Labs for finding of screening colonoscopy
- In network providers
- Not impose cost sharing

Figure 5

Three in Ten Think Most Americans Get Health Insurance through ACA Exchanges or Marketplaces

As far as you know, do more Americans get their health insurance coverage through the exchanges or marketplaces, or do more Americans get their health insurance through an employer or through a government program such as Medicare or Medicaid?



Note: Half-samples were asked about exchanges or marketplaces compared to either employer or government programs. Question wording abbreviated. See topline for full question wording.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted March 6-12, 2017)

Confusion???

- Coding combinations paid at 100% varies from insurer to insurer
- USPSTF is not designed for billing purposes
- Square peg, round hole
- Importance of appropriate coding for accurate provider reimbursement
- Member could have cost sharing applied creating a barrier to preventive care
- If a diagnostic procedure is done when preventive care is provided, member could have cost share for that visit.
- Someone should explain to member
- Confusing to member


Heat exposure on board fishing boat?
There's a code for that!
(ICD-10) V93.22XA
INTELICODE
Intelligent Coding Software

CPT Code 80061

insurer	Insurer	Insurer	insurer	DESCRIPTION
E78.41				elevated lipoprotein
E78.49				other hyperlipidemia
Z00.00	Z00.00		Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Z00.01		Z00.01	Encounter for general adult medical examination with abnormal findings
Z00.121			Z00.121	Encounter for routine child health examination with abnormal findings
Z00.129			Z00.129	Encounter for routine child health examination without abnormal findings
Z01.411				Encounter for gynecological examination (general) (routine) with abnormal findings
Z01.419				Encounter for gynecological examination (general) (routine) without abnormal findings
Z13.220	Z13.220	Z13.220	Z13.220	Encounter for screening for lipoid disorders
Z76.1				Encounter for health supervision and care of foundling
Z76.2				Encounter for health supervision and care of other healthy infant and child
Z83.42	Z83.42			Family history of familial hypercholesterolemia
Z83.430				Family history of elevated lipoprotein(a)
Z83.438				Family history of other disorder of lipoprotein metabolism and other lipidemia
	Z82.49	Z13.6		Family history of ischemic heart disease and other diseases of the circulatory system
				Encounter for screening for cardiovascular disorders

Examples Uncovered

- The following are actual examples of preventive care complaints to the Department:
  - Tubal ligation anesthesia denied as no preauthorization. After DOI complaint was opened the insurer issued a voluntary reversal and was paid as out of network benefit.
  - Pediatric eye exam and preventive well child visit was paid with cost sharing the members were required to pay copay. After DOI complaint was opened the insurer issued a voluntary reversal and was processed correctly.
  - Annual Pap Smear denied as routine care and not a covered service. After DOI complaint was opened the insurer issued a voluntary reversal and paid as preventive service.
  - Colonoscopy paid with cost sharing the claim system did not view dx of polyp as a preventive service. After DOI complaint was opened the insurer issued a voluntary reversal and paid as a preventive service.
  - Colonoscopy with anesthesia balance billing member. Alert member.
  - Denied removal of IUD "routine care is not covered. Except for covered preventive services" MD changed code covered as outpatient services. Coding issue.


THANK
YOU


Any questions?