

MODEL LANGUAGE FOR PREVENTIVE SERVICES

Table of Contents

Section 1.	Definitions
Section 2.	Applicability and Scope
Section 3.	Coverage for Preventive Items and Services
Section 4.	Coverage for Office Visits in Conjunction with Preventive Items and Services
Section 5.	Preventive Items and Services Delivered by Out-of-Network Providers
Section 6.	Reasonable Medical Management Allowed
Section 7.	Additional Services Not Prohibited

Section 1. Definitions.

- A. “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- B. “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.
- C. “Group health plan” means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in subsection K, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.
- D. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Patient Protection and Affordable Care Act (Affordable Care Act) uses the term “health insurance coverage.” The definition of “health benefit plan” is intended to be consistent with the definition of “health insurance coverage” contained in HIPAA. Paragraphs (2), (3), (4), and (5) below track the language of HIPAA that addresses “excepted benefits,” i.e., those benefits that are excepted from the requirements of the Affordable Care Act.

- (2) “Health benefit plan” includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.
- (3) “Health benefit plan” does not include:
 - (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; and

- (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (4) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
- (a) Limited scope dental or vision benefits;
 - (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (5) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
- (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
- (6) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
- (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.
- E. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not “corporate persons.”

- F. “Health care provider” or “provider” means a health care professional or a facility.
- G. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: The Affordable Care Act uses the term “health insurance issuer” instead of “health carrier.” The definition of “health carrier” is consistent with the term “health insurance issuer.”

- H. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for the covered person’s responsibility for copayments, coinsurance or deductibles.

- I. (1) “Individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association or other discretionary group that is not an employer plan, but does not include short-term limited duration insurance.
- (2) For purposes of this subsection, a health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.
- J. “Managed care plan” means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.
- K. “Medical care” means amounts paid for:
 - (1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
 - (2) Transportation primarily for and essential to medical care referred to in paragraph (1); and
 - (3) Insurance covering medical care referred to in paragraphs (1) and (2).
- L. “Network” means the group of participating providers providing services to a managed care plan.

Section 2. Applicability and Scope.

- A. Except as provided in subsection B, these sections apply to any health carrier providing coverage under an individual or group health benefit plan.
- B. (1) These sections do not apply to grandfathered plan coverage.
- (2) For purposes of this subsection, “grandfathered plan coverage” means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010 for as long as it maintains that status in accordance with federal regulations.

Section 3. Coverage for Preventive Items and Services.

- A. A health carrier shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible with respect to the following items and services:
 - (1) Except as otherwise provided in subsection B, evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010 with respect to the individual involved;

Drafting Note: The items and services referenced in paragraph (1) above can be found at this link: <http://www.healthcare.gov/center/regulations/prevention/taskforce.htm>. States should be aware that these items and services could change over time.

- (2) 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 the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

Drafting Note: The recommended immunizations for children, adolescents and adults referenced in Paragraph (2) above can be found at these links: Persons Aged 0 through 6 years—

http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_0-6yrs-schedule-pr.pdf; Persons Aged 7 through 18 years — http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_7-18yrs-schedule-pr.pdf; Catch-up Immunization Schedule for Persons Aged 4 Months through 18 Years — http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_catchup-schedule-pr.pdf; Recommended Adult Immunization Schedule—<http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2010/adult-schedule.pdf>.

- (3) 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; and

Drafting Note: The comprehensive guidelines referenced in paragraph (3) above can be found at these links: <http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>; <http://www.hrsa.gov/heritabledisorderscommittee/SACHDNC.pdf>.

- (4) With respect to women, to the extent not described in paragraph (1), evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- B. (1) (a) A health carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in subsection A after the recommendation or guideline is no longer described in subsection A.
(b) Other provisions of State or federal law may apply in connection with a health carrier's ceasing to provide coverage for any such items or services including section 2715(d)(4) of the Public Health Services Act, which requires a health carrier to give sixty (60) days advance notice to a covered person before any material modification will become effective.
 - (2) For purposes of subsection A and for purpose of any other provision of law, the United States Preventive Services Task Force recommendations regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current.
- C. A health carrier shall at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings by the Health Resources and Services Administration in effect at the time.

Drafting Note: This website: <http://www.HealthCare.gov/center/regulations/prevention.html> is provided in the interim final regulations published in the *Federal Register* July 19, 2010 which health carriers can visit once a year to find information necessary to determine any additional items or services that must be covered without cost-sharing requirements or to determine any items or services that are no longer required to be covered.

Section 4. Coverage for Office Visits in Conjunction with Preventive Items and Services.

- A. A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in section 3 is billed separately or is tracked as individual encounter data separately from the office visit.
- B. A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in section 3 is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.
- C. A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in section 3 is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

Section 5. Preventive Items and Services Delivered by Out-of-Network Providers.

- A. Nothing in these sections requires a health carrier that has a network of providers to provide benefits for items and services described in section 3 that are delivered by an out-of-network provider.
- B. Nothing in section 3 precludes a health carrier that has a network of providers from imposing cost-sharing requirements for items or services described in section 3 that are delivered by an out-of-network provider.

Section 6. Reasonable Medical Management Allowed.

Nothing prevents a health carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in section 3 to the extent not specified in the recommendation or guideline.

Section 7. Additional Services Not Prohibited.

Nothing in these sections prohibit a health carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A health carrier may impose cost-sharing requirements for a treatment not described in section 3 even if the treatment results from an item or service described in section 3.

W:\National Meetings\2010\Fall\TF\RF\Preventive Services Template3adopted.doc