STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Bulletin No. HC-100
November 3, 2014

TO: All Health Insurance Companies and Health Care Centers Authorized to Conduct Business in Connecticut

RE: Health Insurance Coverage for Preventative Services

This Bulletin clarifies the requirements under the Patient Protection and Affordable Care Act. Pub. L. 111-48, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (collectively "ACA") and Connecticut mandates as they apply to issues of preventive and wellness services , with particular focus on women's health and are applicable to plans as of January 1, 2015.

Section 1001 of the ACA which amends § 2713 of the Public Health Service Act, requires that all non-grandfathered group health plans and health insurance issuers offering group or individual coverage must provide coverage of certain preventive services with no cost sharing requirements. While neither the statute nor associated regulation, 45 CFR § 147.130, set the specifics for what is actually required they instead refer to the Health Resources and Service Administration Agency ("HRSA") of HHS and the United States Preventive Services Task Force ("USPSTF") as the entities charged with identifying the appropriate benefits. When referring to USPSTF, the ACA requires only compliance with A and B recommendations.

The Institute of Medicine ("IOM")) in a July 19, 2011 report identified recommendations for Preventive Services. Based on the IOM recommendations, HRSA published guidance in 2011.The USPSTF A and B recommendations are updated as the organization sees appropriate.

GENERAL GUIDANCE

For the designated medical services identified in the HRSA guidelines and USPSTF A and B recommendations, there is no cost sharing allowed under the ACA nor are limits permitted, except where those guidelines/recommendations identify such explicit limits, such as indicating the guideline recommends covering an annual visit. However, reasonable medical management may be applied to all services and only medically necessary medical services are required to be covered.

Reasonable medical management should be based on the statutory definition of "medical necessity" which provides in Conn. Gen. Stat. § 38a-482a:

Medical Necessity means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

WOMEN'S HEALTH

The guidelines and recommendations are heavily weighted with respect to women's health services. When determining what women's preventive services must be covered and to what extent, it is necessary to review each of the referenced authorities and in the case of ambiguities, the Connecticut Insurance Department ("Department") has interpreted eligible coverage requirements to the benefit of the consumer.

With respect to the following topics:

Breastfeeding Support – The ACA requires coverage of breastfeeding supplies, and support and counseling without co-payments, deductibles, or co-insurance, for the duration of breastfeeding. In addition, this would include lactation support and counseling in conjunction with each birth for the duration of the postpartum period. In Connecticut, we have group and individual statutory mandates (See Conn. Gen. Stat. § 38a-503c(d)and Conn. Gen. Stat. § 38a-530c(d)) which provide that in the event a mother and baby are released early from the hospital there shall be a follow up visit within forty-eight hours of discharge and a second follow up visit within seven days of discharge. The Connecticut mandate indicates that follow up services shall include assistance and training in breast or bottle feeding. While no specified period is provided in the statute, insurers have in the past been permitted to limit the support and counseling to specified sessions. The HRSA guidelines indicate that under the ACA, coverage will be required for the duration of breastfeeding, with lactation support and counseling for the duration of the postpartum period. As in the ACA, neither the associated regulation nor HRSA guidelines offer a definition of the term "postpartum period." Since there is no generally accepted medical definition of "postpartum period", medical management should be used to define "postpartum period" for each woman as it relates to breastfeeding support and the Department will no longer permit insurers to limit breastfeeding other than based on medical necessity.

Contraception – The ACA requires that plans cover the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling without patient cost-sharing for all women with reproductive capacity. The Connecticut statutory mandates for group and individual policies require all insurance policies covering outpatient prescription drug coverage to not exclude coverage for prescription contraceptive methods approved by the FDA. (See Conn. Gen. Stat. § 38a-503e (a) and Conn. Gen. Stat. § 38a-530e(a)) Although policies and contracts

have generally not included any cost sharing for these services, there have been some contract provisions that appear to be contradictory. For example, sterilization is often a separate benefit listing outside of contraceptive coverage and may include sterilization procedures for men. In addition, there is typically a general exclusion for all over the counter drugs. Because the ACA's prohibits cost sharing for sterilization procedures for women only, and patient education and counseling, all FDA-approved contraceptive methods for women, including over the counter drugs must be covered. Companies may need to clarify such provisions in their contracts. Sterilization for men is not covered by the ACA under the women's contraception provisions, but may be covered by an insurance company separately. Utilization of these services may be limited based on medical necessity.

Maternity Coverage - The ACA requires that plans cover prenatal care as part of the well woman visit, without patient cost-sharing. Plans must also cover United States Preventive Services Taskforce (USPSTF) A and B recommended services without cost-sharing, including many routine prenatal screenings for women e.g. ultrasounds. The HRSA Guidelines specifically include preconception and prenatal care as elements of the well-woman visits and directs coverage for age and developmentally appropriate preventive services and other screening services as identified by the USPSTF. Services related to maternity that are not preventive may be subject to cost sharing. The HRSA guidelines provide direction on frequency and limits for preventative services. In the absence of guidance, preventative services may be subject to medical necessity.

Consistent with prior filing submissions, language should reference HRSA, USPSTF or IOM rather than list all preventive services. The Department recommends that all Certificates of Coverage include explicit language indicating that not all preventive services are listed and that certain diagnostic services provided in relation to the preventive and wellness services will require cost sharing. The Department further recommends that all Certificates of Coverage should include any appropriate links or advise members to contact their member services representatives for any questions relating to coverage or cost sharing of specific services.

If previously approved filings do not accurately reflect these women's preventive services as described in this bulletin, companies will need to file through SERFF amendatory language to conform to CID interpretation. The cover letter should reference the previously approved filings to which such amendments would apply and the dates previously approved.

Please contact the Insurance Department Life and Health Division at cid.lh@ct.gov with any questions.

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