New Health Plans Must Offer Free Screenings

Coverage will include diabetes and blood pressure tests as well as tobacco cessation counseling.

ARTICLES BY
MARY ELLEN SCHNEIDER

New health plans will soon be required to offer a range of recommended preventive health services to patients free of charge under the Affordable Care Act.

The requirements will affect new private health plans in the individual and group markets starting with plan years that begin on or after Sept. 23. The Health and Human Services department estimates that in 2011, the rules will impact about 30 million people in group health plans and another 10 million in individual market plans. The rules do not apply to grandfathered plans.

The administration released an interim final regulation detailing the new requirements on July 14. Under the final rule, health plans may not collect copayments, coinsurance, or deductibles for various recommended preventive services. But they may collect fees for the associated office visit if the preventive service was not the primary purpose of the visit. Patients may also incur cost sharing if they go out of network for the screenings.

The covered services include those given an evidence rating of "A" or "B" from the U.S. Preventive Services Task Force. Those services include breast and colon cancer screenings, diabetes screenings, blood pressure and cholesterol testing, and screening for vitamin deficiencies during pregnancy. Tobacco cessation counseling is also given a high evidence rating by the task force and would be covered under the new rule.

Health plans will have time to begin covering newly recommended services. For recommendations that have been in effect for less than a year, plans will have 1 year to comply after the effective date, according to the interim final rule.

Health plans will also be required to cover the list of adult and childhood vaccines recommended by the Advisory Committee on Immunization Practices. For children, the rule requires health plans to cover all preventive care recommended under the Bright Futures guidelines. The guidelines include screenings, developmental assessments, immunizations, and regular well-child visits from birth to age 21 years. These guidelines were developed jointly by the Health Resources and Services Administration and the American Academy of Pediatrics.

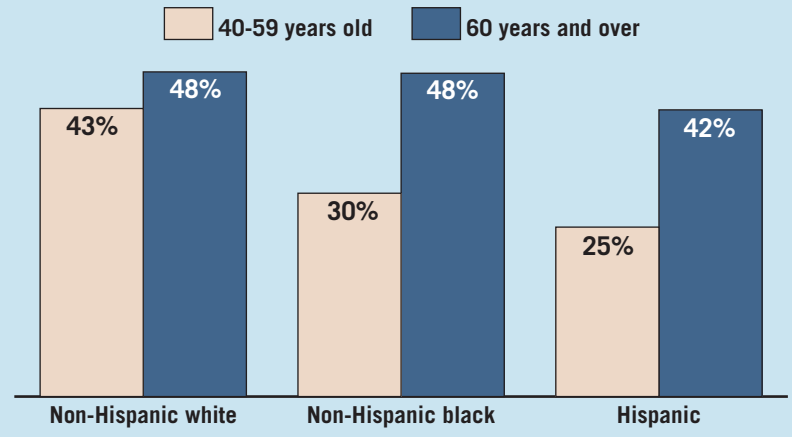
The rule calls for coverage of additional preventive services for women, which will be developed by an independent group of experts. The recommendations from that group are expected by Aug. 1, 2011. There was no word from HHS on whether those recommendations are likely to include coverage for contraceptives, something many reproductive health advocates have been lobbying for in recent months.

HHS officials expect that the move to expand coverage and eliminate out-of-pocket costs for these services will decrease costs for many Americans, especially those at high risk for certain health conditions. The change also is expected to increase premiums for enrollees in nongrandfathered plans. The federal government estimates that premiums in the affected plans could increase about 1.5% on average.

The recommended preventive services are listed at www.healthcare.gov/center/regulations/prevention/recommendations.html. ■

DATA WATCH

Diabetes Patients Aged 40 and Over Who Received All Three Recommended Services* for Diabetes in 2006



*Hemoglobin A_{1c} measurement, dilated eye examination, foot examination
Source: Agency for Healthcare Research and Quality Medical Expenditure Panel Survey

ELSEVIER GLOBAL MEDICAL NEWS

Health Department Proposes Tighter Privacy Requirements

Patients could gain greater access to their health information and have more power to limit disclosures of certain personal information to health plans under a new proposal from the Health and Human Services department.

The new requirements, announced on July 8, are aimed at beefing up privacy and security, as the Obama administration pushes to get more physicians using electronic health records over the next few years.

'The benefits of health IT can only be fully realized if patients and providers are confident that electronic health information is kept private and secure at all times.'

"The benefits of health IT can only be fully realized if patients and providers are confident that electronic health information is kept private and secure at all times," Georgina Verdugo, director of the HHS Office for Civil Rights, said in a statement. "This proposed rule strengthens the privacy and security of health information, and is an integral piece of the administration's efforts to broaden the use of health information technology in health care today."

The proposal alters the Health Insurance Portability and Accountability Act (HIPAA) rules by setting new limits on the use of disclosure of protected health information for marketing and fundraising and by requiring business associates of HIPAA-covered entities to follow most of the same rules that covered entities follow. The proposal would also bar the sale of protected health information without explicit authorization from the patient.

The proposal also implements elements of the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, which requires physicians and other covered entities to grant patient requests to restrict certain information from their health plans.

For example, the proposed rule states that patients must be allowed to restrict protected health information if it is related only to a service for which the patient paid in full and is not otherwise required by law to be reported.

Individuals can provide comments on the rule for 60 days, beginning on July 14. Along with the release of the proposed regulation, HHS has also launched a new Web site (www.hhs.gov/healthprivacy/index.html) that provides consumers with information on their privacy rights under existing regulations. ■

Patients Get New Rights to Appeal Insurance Decisions

New federal regulations mandated by the Affordable Care Act will give patients new rights to appeal claims denials made by their health plans.

The rules, announced on July 22, will allow consumers in new health plans to appeal decisions both through their insurers' internal processes and to an outside, independent entity. While most health plans already provide for an internal appeals process, not all offer an external review of plan decisions, according to the Department of Health and Human Services. The types of appeals processes often depend on individual state laws.

HHS officials estimate that in 2011 there will be 31 million people in new employer plans and another 10 million in new individual market plans who will be able to take advantage of these new appeals opportunities. By 2013, that number is expected to grow to 88 million people. The rules do not apply to grandfathered health plans.

Under the new rules, health plans that begin on or after Sept. 23, 2010 must have an internal appeals process that allows consumers to appeal whenever the plan denies a claim for a covered service or rescinds coverage. The internal appeals process must also offer consumers detailed information about the grounds for their denial and information on how to file an appeal.

The rules aim to make internal appeals more objective by ensuring that the person considering the appeal does not have a conflict of interest. For example, the health plan is not allowed to offer financial incentives to employees based on the number of claims that are denied. Health plans also will have to provide an expedited appeals process, which would allow urgent cases to be reviewed within 24 hours.

The new federal appeals regulations also standardize rules for external appeals. Currently, 44 states require health plans to have some type of external appeal but those processes vary, the HHS reported. Under the federal rules, health plans must provide clear information about external appeals and expedited access to the process. Decisions made through external appeals are binding under the new rules. ■