Preventive care should be free from out-of-pocket costs! Here's what Kentucky Healthcare Providers Should Know:

Since 2014, federal law requires most health insurance plans to cover in-network preventive care at no cost to the patient. A lack of clear rules for providers and insurers has resulted in patients getting stuck paying out-of-pocket costs for care that should be free.

What preventive services should be free?

Covered services are different for adults, women, and children. The full list of services can be found here: https://www.healthcare.gov/coverage/preventive-care-benefits/. Some common services include:

- Cholesterol screening
- Depression screening
- Mammograms for breast cancer
- Help to quit smoking (some insurers)
- Pap smears for cervical cancer
- Colonoscopies or stool-testing for colorectal cancer
- Low-dose CT scans for lung cancer
- Vaccinations
- Annual wellness exams
- Blood pressure screening

An audit conducted by the Department of Insurance (DOI) reviewed claims data from 2014-2015 for five insurers. They found that:

Coding for preventive care claims varies dramatically between insurers.

- 671 CPT codes were used to bill for preventive benefits.
- Of these, only 25% of the codes were considered preventive by all five insurers. The remaining 75% of claims were not coded consistently among insurers.

Differences in codes cause billing errors. The result is that patients get billed for out-of-pocket costs they should not have to pay.

- Kentuckians were charged out-of-pocket costs for 52% of "free" preventive services.
- Billing for "free" services ranged from 21% - 84% depending on the insurer.
- This translated into more than $800,000 in inappropriate cost sharing for preventive care claims.

Charging for "free" services may keep patients from seeking preventive care.

Why are patients being charged for preventive care that should be free?

- A patient schedules a procedure expecting it to be preventive or screening, but due to a past or present diagnosis, medical history or symptoms, the healthcare provider determines that it is diagnostic. The patient may not realize this information and the bill catches the patient by surprise.
- Patients are ineligible for "free" mammograms and potentially other "free screenings" because of symptoms, past diagnosis or history.
- If patients report symptoms, the colonoscopy will be coded as diagnostic.
- Even if a provider codes a service as preventive, if there are symptoms, the insurers may override the coding and it becomes diagnostic.
- There is no clear guidance on the specific codes that providers should use when billing for preventive care to ensure these services are fully covered by the insurer. This has resulted in many Kentuckians getting stuck with bills for services that should be fully covered. Furthermore, individuals who are inappropriately billed for preventive care may not know it is an error or how to fix it.

KY VOICES FOR HEALTH

Kentucky Cancer Consortium
A partnership for life.

HEALTH LITERACY KENTUCKY

Preventive care should be free from out-of-pocket costs! Here's what Kentucky Healthcare Providers Should Know:

Which insurers are required to cover preventive services at no cost?

Almost all plans offered through employers or sold on kynect are required to cover preventive care at no cost to the patient. Individual plans not sold through kynect (such as short-term plans, sharing plans, and "grandfathered" plans) may not cover free preventive care.

Potential Solutions: What can healthcare providers do to help resolve the problem?

Congress has the ultimate responsibility to fix this problem, but Kentuckians need relief now.

- Document in the medical record that the intention of the service is preventive.
- Educate the patient that when symptoms are present, the service is no longer considered preventive and may include additional co-pays or deductibles.
- Inform patients on what to do if they receive a surprise bill for services that were supposed to be preventive. Here are the steps that patients can take.
    1. Contact you (as the provider) and/or insurer to review that the codes identify the service as preventive.
    2. If the patient is covered through their workplace, encourage them to talk with their HR department or employer.
    3. Appeal the insurer determination. This means they can ask the insurer to conduct a full and fair review of the decision.

Here are resources that can support your patients in filing a complaint or appeal:

- **Kentucky Department of Insurance (DOI)** (call 800-595-6053 or complete the online form)
    - The DOI will review the complaint and decide if the patient was billed incorrectly.
    - Appeal the insurer determination, this means the patient can ask their insurer to conduct a full and fair review of its decision and determine if their preventive services were paid correctly. Check with insurer for instruction on their appeal or https://insurance.ky.gov/ppc/Documents/abdappeal071217.pdf
    - If the DOI finds that the insurer incorrectly paid the claim, the DOI will require the insurer to reprocess the claim and the provider will be required to refund the patient. The insurer must respond within 30 days.
- **Attorney General (AG)** (call (502) 696-5389 or 888-432-9257 [select option #3] or complete the online form)
    - The AG's Consumer Protection Division mediation staff will review the complaint and if within their scope under the Kentucky Consumer Protection Act, will issue a written notice on the patient's behalf in an effort to mediate the dispute.
    - These mediation requests can sometimes take the form of phone calls and email exchanges as well.

4. **Contact local legal aid.** Find out what program covers the patient's county here.
    - Kentucky Legal Aid: Western Kentucky (270-782-5740)
    - Legal Aid Society: Louisville and surrounding counties (502-584-1254)
    - Legal Aid of the Bluegrass: Central and Northern Kentucky (859-431-8200)
    - AppalReD Legal Aid: Eastern and South Central Kentucky (866-277-5733)