

## **GENERAL FREQUENTLY ASKED QUESTIONS**

### **What is the Affordable Care Act?**

The Affordable Care Act (ACA) (Public Law 111-148) was implemented on March 23, 2010, and is intended to increase access to health care for more Americans, and includes many changes that impact the commercial health insurance market, Medicare and Medicaid. Parts of the ACA were effective on the implementation date while other parts will be fully in effect in 2014. ACA is also referred to as the “health reform act” or “Patient Protection and Affordable Care Act” (PPACA).

### **What provisions are effective immediately?**

The ACA creates a sliding scale tax credit to small employers with fewer than 25 employees and average annual wages of less than \$50,000 that purchase a health plan for their employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. To be eligible for a tax credit, the employer must contribute at least 50% of the total premium cost or 50% of a benchmark premium.

In 2010 through 2013, eligible employers can receive a small business tax credit for up to 35% of their contribution toward the employee’s health insurance premium. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25% of their contribution. In 2014 and beyond, eligible employers who purchase coverage through the State Exchange (described in a later Q&A) can receive a tax credit for 2 years up to 50% of their contribution. (For more information: IRS Frequently Asked Questions on the Small Business Health Care Tax Credit)

### **What provisions were effective 90 days after enactment?**

The Secretary is to establish a temporary pre-existing condition insurance plan (PCIP) to provide coverage to individuals with pre-existing conditions who have been without coverage for at least 6 months. The ACA provides \$5 billion to fund these programs through 2013. See <https://www.pcip.gov/> for details.

### **What provisions were effective July 1, 2010?**

The Secretary, in consultation with the States, established a website through which individuals and small businesses may identify affordable health insurance coverage. It includes information on health insurance coverage, Medicaid, CHIP, Medicare, a PCIP, small group coverage, reinsurance for early retirees, tax credits, and other information. See <http://www.healthcare.gov/index.html> for details.

### **What benefit changes were effective on September 23, 2010?**

Health plans may not establish lifetime limits on the dollar value of essential benefits.

Health plans may only establish restricted annual limits prior to January 1, 2014, on essential benefits as determined by the Secretary.

Health plans must provide coverage without cost sharing for certain preventative services:

- Services recommended by the US Preventive Services Task Force;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC;
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration;
- Preventive care and screenings for women supported by the Health Resources and Services Administration.

Health plans may not exclude coverage for children under age 19 due to pre-existing conditions.

A health plan that provides for designation of a primary care provider must allow the choice of any preferred primary care provider who is available to accept them, including pediatricians.

If a health plan provides coverage for emergency services, the health plan must do so without prior authorization, regardless of whether the provider is a preferred provider. Services provided by non-preferred providers must be provided with cost sharing that is no greater than that which would apply for a preferred provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, or cost-sharing.

A health plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a preferred provider and must treat their authorizations as the authorization of a primary care provider.

**What changes in coverage availability were effective September 23, 2010?**

The ACA provides that coverage may be rescinded only for fraud or intentional misrepresentation of material facts prohibited by the terms of coverage.

Health plans that provide dependent coverage must extend coverage to adult children up to age 26. Carriers are not required to cover children of adult dependents.

**What other changes were effective September 23, 2010?**

All health plans must submit certain practices and data to the Secretary and State Insurance Commissioner, and make them available in plain language to the public. This includes claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, data on the number of claims that are denied, data on rating practices, information on cost-sharing and payments with respect to

out-of-network coverage, and other information as determined appropriate by the Secretary.

With respect to appeals, group health plans must incorporate the Department of Labor's (DOL) claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. Individual health plans must incorporate applicable ACA requirements and update them to reflect standards established by the Secretary. All health plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the National Association of Insurance Commissioners (NAIC) Uniform External Review Model ACA or minimum standards established by the Secretary.

### **What changes affecting medical cost ratios apply beginning in 2011?**

Issuers must provide the Secretary a report concerning the ratio of incurred losses plus loss adjustment expenses to earned premiums. This report must include the percentage of total premium revenue that is expended on reimbursement for clinical services, activities that improve health care quality, and all other non-claims expenses. Issuers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets.

The Secretary, together with the states, is to develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process will require issuers to submit to the State and the Secretary a justification for an unreasonable premium increase and post it online.

### **What does the ACA require for benefit descriptions?**

The Secretary must develop standards for a summary of benefits and coverage explanation to be provided to all potential policyholders and enrollees. The summary must contain:

- Uniform definitions of insurance and medical terms;
- A description of coverage and cost sharing for each category of essential benefits and other benefits;
- Renewability and continuation of coverage provisions;
- A "coverage facts label" that illustrates coverage under common benefits scenarios;
- A statement of whether it provides minimum essential coverage with an actuarial value of at least 60% that meets the requirements of the individual mandate;
- A statement that the outline is a summary and that the actual policy language should be consulted; and,
- A contact number for the consumer to call with additional questions and the web address of where the actual policy language can be found.

The Secretary must consult with the NAIC, as well as a working group of issuers, providers, patient advocates, and those representing individuals with limited English proficiency.

Uniform documents are to be implemented by March 23, 2012.

**What rules does the ACA require regarding electronic transactions?**

It requires the Secretary to develop operating rules for the electronic exchange of health information, transaction standards for electronic funds transfers, and requirements for financial and administrative transactions by July 1, 2011. The requirements are to become effective January 1, 2013.

**What reporting requirements apply on March 23, 2012?**

Health plans must submit annual reports to the Secretary on whether the benefits under the health plan improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management, whether they implement activities to prevent hospital readmission, and whether they implement activities to improve patient safety and reduce medical errors.

**What benefit changes does the ACA require beginning January 1, 2014.**

No health plan may discriminate on the basis of a pre-existing condition or past illness.

The ACA prohibits discrimination against health care providers acting within their licensure and within state laws.

The ACA requires issuers to include coverage with essential benefits of a defined actuarial value, and for all health plans to comply with cost-sharing limitations.

Health plans must implement wellness and health promotion activities.

**What rating requirements apply beginning January 1, 2014?**

Premiums may vary only by family structure, geography, plan design, age (within a 3:1 band) and tobacco use (within a 1.5:1 band).

Reforms must be applied uniformly in each relevant market.

**What availability requirements apply beginning January 1, 2014?**

The ACA will require each issuer to accept every employer and individual in the state that applies for coverage, allowing for annual and special open enrollment periods.

Issuers will be prohibited from setting eligibility rules based on health status, medical history, genetic information or evidence of insurability.

Employers could vary premiums by as much as 30% for employee participation in certain health promotion and disease prevention.

Discrimination against health care providers acting within the scope of their certification or applicable state law will be prohibited.

Issuers will be prohibited from applying any waiting period exceeding 90 days.

### **Do people have to change the plans they are in now?**

The ACA includes a “grandfathering” provision that will allow people to keep the plans they had on the date of enactment, subject to some changes, as discussed below. This means that an individual does not have to terminate coverage they had as of the Act’s enactment date. Additionally, existing group health plans may allow new employees and dependents to join the “grandfathered” plans, and new dependents can be added to “grandfathered” plans.

Existing group grandfathered health plans will have to be amended to:

- Reduce the waiting period such that it is no longer than 90 days;
- Remove lifetime benefit limits;
- Comply with the limitation on annual limits;
- Allow the extension to age 26 but limited to an adult child who is not eligible for enrollment in an employer-sponsored plan until 2014;
- Provide the uniform coverage documents; and,
- Apply the standard definitions.

### **What is the individual mandate?**

Beginning in 2014, most individuals will be required to maintain minimum essential health coverage or pay a penalty. For those under 18, the penalty will be one-half the amount for adults. Exceptions to this requirement will be made for religious objectors, those who cannot afford coverage, taxpayers with incomes less than 100% of the federal poverty level (FPL), Indian tribe members, those who receive a hardship waiver, individuals not lawfully present, incarcerated individuals and those without coverage for less than 3 months during the previous year.

### **Would employers be subject to penalties?**

The ACA will require employers with 200 or more employees to automatically enroll employees into health plans offered by the employer. The employees would be able to opt out if they had other health coverage.

Employers with more than 50 employees that do not offer a health plan would be required to pay a \$2,000 penalty for each employee who receives a subsidy through a state exchange.

Employers with more than 50 employees offering a health plan but with at least one full-time employee receiving the premium assistance tax credit would pay a penalty of the lesser of \$3,000 per employee receiving a tax credit or \$2,000 per full-time employee.

The ACA will prohibit an employer from discharging or discriminating against an employee on the basis of the employee receiving a premium tax credit.

### **What is a health insurance “Exchange”?**

The ACA requires states to establish a governmental agency or non-profit entity to make available qualified health plans. These will be known as “Exchanges” and are to be made available by 2014. All legal state residents who are not incarcerated could enroll in qualified health plans through the Exchange.

Issuers could offer one or more of four types of health plans: bronze, silver, gold and platinum. The plans would provide increasing levels of services covered and limits on out-of-pocket spending. In addition, issuers could offer a catastrophic plan to those individuals under 30 years of age or those exempt from the individual mandate because no affordable health plan is available to them or exempt because of hardship. The catastrophic plan is available only in the individual market.

State Exchanges will be required to:

- Operate a toll-free hotline and website;
- Rate qualified health plans;
- Inform individuals of Medicaid and CHIP eligibility;
- Provide an electronic calculator to calculate plan costs;
- Grant certifications of exemption from the individual responsibility requirement;
- Allow regional or interstate exchanges if agreed to by the states and approved by the Secretary;
- Include a Small Business Health Operating Program to help small businesses enroll their employees in qualified health plans; and,
- Submit annual accounting reports to the Secretary.

Members of Congress and their staff could be offered only qualified health plans through Exchanges.

## **SPECIFIC FREQUENTLY ASKED QUESTIONS**

### **Annual Limits**

#### **What is the effective date of the restricted annual limit mandate?**

Restricted annual limits on Essential Health Benefits will be allowed according to the following schedule:

- For a plan year beginning on or after September 23, 2010, but before September 23, 2011, no less than \$750,000 limit on Essential Health Benefits.
- For a plan year beginning on or after September 23, 2011, but before September 23, 2012, no less than \$1,250,000 limit on Essential Health Benefits.
- For a plan year beginning on or after September 23, 2012, but before January 1, 2014, no less than \$2,000,000 on Essential Health Benefits.
- The complete prohibition on annual benefit limitations for Essential Health Benefits is effective for plan years beginning on or after January 1, 2014.

**The ACA appears to prohibit unreasonable annual limits on the dollar value of benefits. Are health issuers allowed to have annual visit or day limits?**

The DOL has informally commented that frequency limits are generally acceptable. Such limits, however, should not “transcend” into dollar limits. For example, a frequency limit of 10 visits alone may be acceptable, but if the health plan also places a cap on reimbursement, such as \$50 per visit, the net result would be a \$500 annual limit. In such cases, the DOL suggested that tying the payment to reasonable and customary expenses, or similar action, may rectify the annual limit issue.

**Does the ACA apply to both fully insured and self-funded group plans?**

This provision applies to group health plans, both self-funded and fully insured group health plans. Individual health plans that are grandfathered are not subject to the restricted annual limits provision.

**Do grandfathered health plans have to implement the restricted annual limits?**

Grandfathered group health plans (but not individual insurance coverage) are subject to the restricted annual limits provision on the first plan year on or after September 23, 2010. An individual health plan that is a grandfathered health plan would not have to implement the restricted annual limits.

**Do the restricted annual limits apply to all benefits that may be offered under a group health plan?**

No. The restriction on annual benefit limits only applies to Essential Health Benefits as defined under the Act. This means that health plans may enforce annual benefit limits on non-Essential Health Benefits.

**If the health plan offers coverage for preferred and non-preferred provider services, can annual benefit limits be placed on the non-preferred provider benefits as long as the preferred provider benefits comply with the “no limits” requirement?**

The DOL has informally clarified that the restriction and eventual prohibition on limits with regard to essential health benefits applies to both preferred and non-preferred provider services.

**Do these limits apply to pharmacy benefits or just medical benefits?**

Annual limit provisions apply to all health plans. These limits apply equally to pharmacy and medical benefits since both are benefits and both are included in the categories of Essential Health Benefits.

Therefore, an overall pharmacy maximum would need to be removed. However, a limit on fertility drugs, for example, can be retained since infertility treatment is considered a non-Essential Health Benefit.

**Dependent Children**

**What is the definition of “dependent” as it applies to the ACA?**

ACA regulations provide that a health plan may base eligibility for dependent child coverage only in terms of the relationship between a child and participant, and may not deny or restrict coverage based on factors such as: financial dependency, residency, student status, employment or marital status.

**According to the ACA, which types of health plans need to cover adult children until age 26?**

The ACA applies to all health plans that offer dependent coverage.

**Do grandfathered health plans have to cover a child up to age 26?**

Yes, but they are not required to offer coverage to a child that is eligible for other employer-sponsored coverage. After 2014, they have to offer coverage to a child up to age 26, without restriction.

**Since married dependents are covered, does that mean the spouse of the dependent or the children of the dependent would be covered?**

No. The ACA does not require that the spouse of the dependent be covered, nor does it require that the dependent of a dependent be covered (which is a grandchild).

**On the date of the employer group health plan’s next renewal and open enrollment, can dependent children of covered employees under age 26 be added back to the employee’s group health plan?**

Yes, the ACA’s regulations state that any covered child under age 26, whose coverage ended, or who was denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll under a 30-day transition period. The 30-day period may or may not coincide with the employer group health plan’s open enrollment.

**If an employer’s group health plan does not have an annual open enrollment, does the employer’s group health plan still have to offer a 30-day transition period?**

Yes, the ACA's regulations state that any covered child under age 26, whose coverage ended, or who was denied coverage (or was not eligible for coverage), because the health plan did not previously cover dependent children to age 26, is eligible to enroll. They will have a right to enroll under a special 30-day transition period beginning on the health plan's renewal year. Employees who wish to add dependents may do so whether they need to change their enrollment status from single or employee/spouse to a status that allows dependents, or if they were not previously enrolled in a health plan but wish to do so and add a dependent.

**Are health plans required to verify student status for this new class of eligible dependents (adult children)?**

No, student status can no longer be used to determine dependent status after the effective date of the ACA.

**If a dependent loses a job that provides coverage, is that a qualifying event to move to the parent's coverage?**

The ACA's regulations do not address this specific scenario. However, it is believed that the health plan would be required to cover the dependent.

**If a dependent who is 26 or younger loses his/her employer health plan, do they have to exhaust COBRA first, or can they go immediately on to their parent's health plan?**

Neither the ACA nor the regulations address this. However, normally when a dependent loses coverage through their own employer, that dependent may enroll as a dependent on their parent's health plan because it is considered a special enrollment event under HIPAA (e.g., loss of other coverage); and the dependent does not have to enroll in COBRA or exhaust their COBRA coverage.

**If a dependent is already on COBRA and is under the age of 26, can the dependent enroll onto the parent's health plan at renewal?**

Yes.

**If COBRA ends, is that a qualifying event to move to the parent's health plan?**

Yes, assuming the adult child is under age 26.

**Is the applicable age of dependent coverage up to 26 or through the age of 26 (does it end on a birthday)?**

Coverage must be allowed to continue until the child reaches the age of 26. Sponsors of group health plans will be required to make dependent coverage available to children up until that day. Plan sponsors are free to elect more generous benefit designs, if available to them, such as covering dependents until the end of the month or even the year in which the child attained the age of 26.

**Is the parent's employer allowed to alter the contribution requirement for coverage dependents?**

No. Dependents up to age 26 are not considered overage dependents. For dependents under the age of 26, the health plan must treat dependents uniformly and may not charge more or have a different benefit structure for dependents based on age.

## **Lifetime Limits**

### **What is the effective date of the lifetime limit mandate?**

No health plan may impose lifetime limits on the Essential Health Benefits of a health plan after the ACA effective date.

### **Does the restriction apply to all benefits that may be offered under a group health plan?**

No. The restriction on lifetime limits only applies to Essential Health Benefits as defined under the ACA. Health plans may enforce lifetime limits on specific covered benefits that are non-Essential Health Benefits.

### **While the provisions prohibit lifetime dollar limits, are health plans still allowed to have frequency limits - such as annual visit or other treatment limits?**

The ACA and the interim final rule prohibit the use of lifetime limits on the dollar amount of benefits for an individual. Nothing in the rule would appear to prohibit the use of lifetime visit limits or other treatment limits.

### **What happens to enrollees that have already reached their lifetime benefit limit (maximum) under the health plan before the effective date of this provision? Would they be eligible for additional benefits under the health plan?**

Once the lifetime limits provision becomes applicable to a health plan, the health plan must give the individual a written notice that the lifetime limit no longer applies and that the individual, if covered, is eligible for benefits.

## **Medical Loss Ratio (MLR)**

### **What does the MLR Interim Final Rule (IFR) address?**

The IFR provides guidance to fully insured health plans regarding reporting and calculation of MLR and, where applicable, the criteria for when rebates are required.

### **What is the required MLR as outlined under the Rule?**

- Individual and Small Group Market – 80%.
- Large Group Market – 85%.
- Special considerations for small plans, new plans, mini-med and expatriate plans are accounted for in ACA.

**What defines the small and large group employer market?**

The ACA regulations state that a small group is 1 to 100 lives and large group is 101+ lives. There is also a provision that allows a state to define small group as 1 to 50 lives for purposes of MLR reporting and rebate payment until 2016. In Alabama, small group will continue to be defined as 2-50 lives until 2016, at which time the definition will be changed to 1-100 lives.

**When is the MLR IFR scheduled to go into effect?**

January 1, 2011. All rebates applicable to 2011 will be paid out in August 2012.

**What is counted in the MLR calculation?**

Calculation is based on the incurred claims and the expenses for activities that improve health care quality divided by earned premium less federal and state taxes, licensing and regulatory fees and adjusted for receipts for risk adjustments, risk corridors, and reinsurance under the ACA.

**What is considered an activity that improves health care quality?**

Activities that improve health care quality, increase the likelihood of desired health outcomes and are grounded in evidence-based medicine are to be included in medical costs for the MLR calculation.

Quality improvement programs are designed to achieve the following goals:

- Improve health outcomes including an increased likelihood of desired outcomes compared to a baseline and reduced health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;
- Increase wellness and promote healthy activities; or,
- Enhance the use of health care data to improve quality, transparency, and outcomes.

Quality improvement activities must be designed to improve the quality of care received by an enrollee and be able to be objectively measured for producing verifiable results and achievements.

**Have accommodations been made if changes to MLR could destabilize the market?**

Yes. The Rule establishes a process for state insurance commissioners to request a waiver of the 80% MLR requirement when the Insurance Commissioner determines there is a "reasonable likelihood" that destabilization will occur when the MLR requirement is applied. This waiver applies only to the individual market.

**What are insurance company reporting requirements to the Secretary?**

Each health insurer must report to the Secretary, among other things, the premium earned, claims, quality improvement expenses and other non-claims cost incurred under health plans that are in force during the calendar year. These reports must be by legal entity, state and line of business (individual, small group and large group).

### **What is the general requirement for rebates based on MLR?**

For each MLR reporting year, an insurer must provide a rebate to each enrollee if the issuer's MLR does not meet or exceed the minimum MLR percentage required.

### **Who is eligible for rebate?**

For the sole purpose of determining who is entitled to receive a rebate, the term "enrollee" means the subscriber, policyholder, and/or government entity that paid the premium for health care coverage received by an individual during the respective MLR reporting year.

### **When would the rebates be issued?**

The insurer must provide any rebate owed no later than August 1 following the end of the MLR reporting year.

## **Patient Protections**

### **How will health plan members be advised about their rights to select a primary care provider (PCP), including services from an OB/GYN?**

Health plans and issuers are required to provide notice informing each health plan member about:

- The terms of the health plan or coverage regarding designation of a primary care provider;
- The rights of the member to designate a PCP or pediatrician; and,
- The fact that the health plan or issuer may not require authorization or referral for OB/GYN care by a participating health care professional who specializes in OB/GYN care.

Notice must be provided whenever the health plan or issuer provides a member with a summary plan description or other similar description of benefits under the health plan.

### **What are the new rules regarding selection of PCPs?**

For those health plans and issuers with a network of providers who require or permit a member to designate a PCP, the rules protect the member's ability to designate a PCP, and to direct access to in-network OB/GYN providers.

- Designation of a PCP. Under the new rules, health plan members are free to designate any available participating primary care provider as their PCP.
- Designation of a Pediatrician as a PCP. The rules also provide that parents may choose any available participating physician who specializes in pediatrics (allopathic or osteopathic) to be their children's PCP.

- **Direct Access to In-Network OB/GYN Providers.** Under the rules, health plans and issuers are prohibited from requiring a prior authorization or referral to access a preferred health care professional who specializes in obstetrics or gynecology. A health care professional who specializes in OB/GYN care is any individual who is authorized under state law to provide such care, and is not limited to a physician. The direct access requirement does not waive any exclusions of coverage under the plan with respect to coverage of OB/GYN provider from notifying the member's PCP about the treatment plan. However, the treatment and ordering of services by the OB/GYN provider must be treated as an authorization by the PCP.

### **How do the patient protection provisions enhance access to emergency department services?**

The rules outlined below apply to health plans and issuers that provide benefits for emergency services in an emergency room of a hospital.

- **Prior Authorization Prohibited.** The rules prohibit prior authorization requirements for emergency services, even if a non-preferred provider provides the emergency services.
- **Cost Sharing (Coinsurance and Copayment) Restrictions.** The rules also prohibit health plans and issuers from charging higher cost sharing for emergency services that are obtained out of a health plan's network.
- **Calculating a Reasonable Allowed Amount with Respect to Balance Billing.** The rule does not prohibit balance billing, but requires that a "reasonable amount" be paid before the member is subject to balance billing.
- **Anti-Abuse Rule.** This rule includes an anti-abuse rule with respect to other cost sharing requirements so that the purpose of limiting copayment and coinsurance amounts for emergency services rendered by non-preferred providers cannot be obstructed by manipulation of other cost-sharing requirements.
- **Application of Other Plan Requirements.** The emergency services must be provided without regard to any other term or condition of the health plan other than the exclusion or coordination of benefits, an affiliation or waiting period, or applicable cost-sharing requirements.
- **Prohibition on More Restrictive Administrative Requirements.** Health plans and issuers may not impose an administrative requirement or limitation on benefits for non-preferred provider emergency services that is more restrictive than the requirements or limitations that apply to preferred provider emergency services.

Note, the rules regarding emergency services do not apply to grandfathered health plans.

### **Pre-existing Conditions**

**Does the pre-existing condition of the ACA apply to any enrollee under the age of 19, or just dependent children?**

The ACA includes any enrollee under the health plan that is under the age of 19. For example, an enrollee could be an employee, spouse, or dependent child.

**What is the effective date of the pre-existing condition limits?**

This provision becomes effective for plan/policy years beginning on or after September 23, 2010, and applies to all health plans, except individual grandfathered health plans.

**How does the pre-existing condition limitation for children under 19 work with the current HIPAA/continuous creditable coverage exception for newborn/newly-adopted children?**

Newborns and newly adopted children are, by definition, under the age of 19 and would be protected by the pre-existing condition prohibition contained in the Act.

**Would the Continuous Creditable Coverage concept apply only to enrollees 19 and over?**

Yes, until 2014, health plans may still impose pre-existing conditions on persons who are age 19 and older. These enrollees will, however, be allowed to use their Creditable Coverage to offset a pre-existing condition exclusion as is the case under current law.

**Preventive Care**

**Are cost-sharing obligations prohibited for preventive care?**

Yes, all non-grandfathered health plans and issuers are prohibited from imposing cost sharing requirements for the recommended preventive services when those services are provided by preferred providers. Health plans and issuers are not required to cover preventive services provided by non-preferred providers. If such services are covered, a health plan or issuer may impose cost-sharing requirements for recommended services delivered by non-preferred providers. The health plan or issuer may still charge for an office visit. If the preventive service is billed separately from an office visit, the health plan or issuer may impose cost sharing on the office visit. If the preventive service is not described in the rule, then the health plan or issuer may impose cost sharing.

**Are copayments for preventive care prohibited? What about coinsurance and deductibles?**

All cost sharing mechanisms are prohibited.