SALUS GROUP

Health Plans: Preventive Care Coverage Requirements

The Affordable Care Act (ACA) requires non-grandfathered health plans and health insurance issuers to cover certain preventive health services without imposing cost-sharing requirements when the services are provided by in-network providers. These preventive health services include, for example, many cancer screenings, blood pressure, diabetes and cholesterol tests, vaccinations against diseases, and counseling on topics such as quitting smoking and losing weight. This coverage mandate also includes preventive health services for women, such as well-woman visits, breastfeeding support, domestic violence screening and contraceptives.

Plans and issuers may impose cost-sharing requirements on preventive care services that individuals receive from out-of-network providers. Also, plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment or setting for preventive care services, if they are not specified in the coverage guideline.

This Compliance Overview summarizes the ACA's first-dollar preventive care coverage requirements.

Coverage of Preventive Care Services

Non-grandfathered group health plans and issuers must cover certain preventive care services and may not charge copayments, coinsurance or deductibles for these services when delivered by an in-network provider. The recommended preventive care services covered by these requirements are:

- Evidence-based items or services with an A or B rating in recommendations of the U.S. Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents and adults recommended by the Advisory Committee on Immunization Practices (ACIP);
- Evidence-informed preventive care and screenings in guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and
- Other evidence-informed preventive care and screenings in HRSA-supported guidelines for women.

Plans and issuers may impose cost-sharing requirements on preventive care services that individuals receive from out-of-network providers. Also, plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment or setting for preventive care services, as long as they are not specified in the recommendation or guideline.

The ACA's preventive care guidelines are periodically updated based on new medical research and recommendations. Updated guidelines generally take effect for **plan years beginning on or after one year from the date the updated guideline is issued**.

UPDATE: Litigation Regarding Preventive Care Mandate

In March 2023, the U.S. District Court for the Northern District of Texas struck down a key component of the ACA's preventive care mandate. The District Court ruled that the preventive care coverage requirements based on an A or B rating by the USPSTF on or after March 23, 2010, the ACA's enactment date, violate the U.S. Constitution. The District Court also issued a nationwide injunction, prohibiting the Biden administration from enforcing the affected preventive care mandates against any health plans or issuers. On appeal, the 5th Circuit put the District Court's decision on hold pending its ruling, which means health plans and issuers have been required to fully comply with the ACA's preventive care mandate without interruption.

On June 21, 2024, the 5th Circuit upheld the District Court's ruling that a key component of the ACA's preventive care mandate is unconstitutional. However, the 5th Circuit limited its relief to the plaintiffs in the case and held that there was no basis for a nationwide injunction. Due to the 5th Circuit's ruling, health plans and issuers must continue to cover the full range of recommended preventive care items and services without cost sharing. However, the future of the ACA's free preventive care mandate remains uncertain as this case moves through the legal system. Employers should continue to watch for developments on this issue, as it is likely that the 5th Circuit's decision will be appealed to the U.S. Supreme Court.

Preventive Care Benefits for Adults

Non-grandfathered health plans and issuers must cover the following preventive care services for adults without cost sharing when they are delivered by an in-network health care provider:

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol misuse screening and counseling
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
- Blood pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults 45 to 75
- Depression screening
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
- Diet counseling for adults at higher risk for chronic disease
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting
- Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
- Hepatitis C screening for adults age 18 to 79 years
- HIV screening for everyone age 15 to 65, and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use
- Immunizations for adults (doses, recommended ages and recommended populations vary): Chickenpox (Varicella); Diphtheria; Flu (influenza); Hepatitis A; Hepatitis B; Human Papillomavirus (HPV); Measles; Meningococcal; Mumps; Whooping Cough (Pertussis); Pneumococcal; Rubella; Shingles; and Tetanus
- Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Statin preventive medication for adults 40 to 75 at high risk
- Syphilis screening for adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening for certain adults without symptoms at high risk

Preventive Care Benefits for Children

Non-grandfathered health plans and issuers must cover the following preventive care services for children without cost sharing when they are delivered by an in-network health care provider:

- Alcohol, tobacco and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children
- Bilirubin concentration screening for newborns
- Blood pressure screening for children
- Blood screening for newborns
- Depression screening for adolescents beginning routinely at age 12
- Developmental screening for children under age 3
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders
- Fluoride supplements for children without fluoride in their water source
- Fluoride varnish for all infants and children as soon as teeth are present

- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns and regular screenings for children and adolescents as recommended by their provider
- Height, weight and body mass index (BMI) measurements taken regularly for all children
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents at higher risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- PrEP HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
- Immunizations for children from birth to age 18 (doses, recommended ages and recommended populations vary): Chickenpox (Varicella); Diphtheria, tetanus, and pertussis (DTaP); Haemophilus Influenza type b; Hepatitis A; Hepatitis B; Human Papillomavirus (HPV); Inactivated Poliovirus; Influenza (flu shot); Measles; Meningococcal; Mumps; Pneumococcal; Rubella; and Rotavirus
- Lead screening for children at risk of exposure
- Obesity screening and counseling
- Oral health risk assessment for young children from 6 months to 6 years
- Phenylketonuria (PKU) screening for newborns
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children
- Well-baby and well-child visits

Preventive Care Benefits for Women

Non-grandfathered health plans and issuers must cover additional preventive care services for women without cost sharing when they are delivered by an in-network health care provider, as outlined below.

Services for Pregnant Women (or Women Who May Become Pregnant)

- Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
- Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (certain exceptions apply)
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Maternal depression screening for mothers at well-baby visits
- Preeclampsia prevention and screening for pregnant women with high blood pressure
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening
- Expanded tobacco intervention and counseling for pregnant tobacco users
- Urinary tract or other infection screening

Other Preventive Care Services for Women

- Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause
- Breast cancer genetic test counseling (BRCA) for women at higher risk
- Breast cancer mammography screenings, with or without clinical breast examination, every 1-2 years for women 40 and older
- Breast cancer chemoprevention counseling for women at higher risk
- Cervical cancer screening (Pap test) for women age 21 to 65
- Chlamydia infection screening for younger women and other women at higher risk

- Diabetes screening for women with a history of gestational diabetes who are not currently pregnant and who have not been diagnosed with type 2 diabetes before
- Domestic and interpersonal violence screening and counseling for all women
- Gonorrhea screening for all women at higher risk
- HIV screening and counseling for everyone age 15 to 65, and other ages at increased risk
- PrEP HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use
- Sexually transmitted infections counseling for sexually active women
- Tobacco use screening and interventions
- Urinary incontinence screening for women yearly
- Well-woman visits to get recommended services for all women

Contraceptive Coverage – Exceptions

The HRSA-supported guidelines recommend that adolescent and adult women have access to the full range of contraceptives and contraceptive care. Non-grandfathered health plans and issuers must cover without cost sharing:

- At least one form of contraception in each of the categories listed in HRSA's guidelines (e.g., intrauterine devices with progestin, injectable contraceptives, oral contraceptives-combined pill, emergency contraception-levonorgestrel and sterilization surgery for women); and
- Any contraceptive services and FDA-approved, -cleared or -granted products that an individual's health care provider determines to be medically appropriate (including newer contraceptive products, regardless of whether they are included in HRSA's guidelines).

Exemptions to the ACA's contraceptive coverage requirement are available to religious employers and eligible employers who object to providing this coverage based on their sincerely held religious beliefs or moral convictions. An optional accommodation approach is also available for employers who object to this coverage. The accommodation process allows an employer to avoid providing coverage for contraceptives under its health plan while requiring the employer's issuer or third-party administrator (TPA), as applicable, to separately provide or arrange for this coverage.

Exemption for Churches

Group health plans of certain nonprofit religious employers (such as churches and other houses of worship) are exempt from the ACA's contraceptive coverage requirement. Under this exemption, eligible employers offering health coverage may decide whether to cover contraceptive services, consistent with their beliefs. A "religious employer" is defined as a nonprofit entity that is referred to in Internal Revenue Code (Code) Section 6033(a)(3)(A)(i) or (iii). This definition primarily includes churches, other houses of worship and their affiliated organizations.

Exemptions for Other Employers

On Nov. 7, 2018, the Departments of Health and Human Services, Labor and the Treasury (Departments) issued the following two final rules to expand the number of employers who are eligible for an exemption from the ACA's contraceptive coverage mandate:

- Objection based on religious beliefs: The first final rule provides a broad exemption for employers who object to providing contraceptive coverage based on their sincerely held religious beliefs.
- Objection based on moral convictions: The second final rule provides an exemption for certain employers who object to providing contraceptive coverage based on their sincerely held moral convictions (but not religious beliefs).

In addition, the final rules changed the accommodation approach for employers who are eligible for an exemption so that it is a voluntary option instead of a mandatory process. Under the accommodation process, employers can exclude contraceptive coverage from their health plans, while participants and beneficiaries receive contraceptive coverage or payments arranged by their issuers or TPAs.

Proposed Changes: On Jan. 20, 2023, the Departments released a proposed rule to expand access to contraceptive coverage without cost sharing. The proposed rule would **rescind the moral exemption** to covering contraceptives but retain the existing religious exemption. The proposed rule would also **establish a new way for individuals to access contraceptives at no cost** when they are enrolled in plans that qualify for an exemption and do not use the optional accommodations process. Under the proposed rule, individuals would be able to obtain contraceptive services at no cost directly from a willing health care provider. At this time, the changes are only in the proposed form and have not been finalized.

LINKS AND RESOURCES

- Final rules from July 2015, relating to the coverage of preventive health services under the ACA.
- HRSA guidelines regarding women's preventive health care services.
- A list of recommended preventive services is available at: www.healthcare.gov