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# New FAQs on ACA Preventive Care Services

The departments have issued FAQs clarifying the range of services that must be covered by non-grandfathered group health plans under the preventive services mandate. The FAQs address coverage for breast cancer screening, FDA-approved contraceptives, sex-specific preventive services and coverage of anesthesia associated with colonoscopies. These FAQs contain important clarifications that may require some plan changes.

## Background

The Affordable Care Act (ACA) requires non-grandfathered group health plans to cover certain preventive care services without cost-sharing. (See our July 20, 2010, March 15, 2013 and June 10, 2014 issues of *For Your Information.*) These include:

- Evidence-based items or services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved
- Immunizations for routine use in children, adolescents and adults that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention
- Evidence-informed preventive care and screenings for infants, children and adolescents provided in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)
- Evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF for women

If a recommendation or guideline does not specify the frequency, method, treatment or setting for the provision of that service, the plan can use reasonable medical management techniques to determine coverage limitations.

## New Guidance

On May 11, 2015, the Departments of Labor, Health & Human Services, and Treasury (departments) issued FAQs responding to questions about some of the required preventive services.

## BRCA Testing

One of the USPSTF-recommended services is a screening for women who have a family member with breast, ovarian, tubal or peritoneal cancer. The screening is used to identify a family history potentially associated with an increased risk for mutations in breast cancer susceptibility genes (BRCA). Women with a positive screening result should receive genetic testing and, if necessary, BRCA testing. The FAQ clarifies that this recommendation also applies to women who previously have had breast cancer, ovarian cancer or other non-BRCA-related cancer, but are currently asymptomatic and cancer-free.

## Coverage of Contraceptives

An HRSA guideline recommendation includes all FDA-approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, as prescribed by a healthcare provider. The FAQs clarify that plans must cover without cost-sharing at least one form of contraception in each of the currently 18 distinct methods the FDA has identified in its Birth Control Guide. This includes patient education and counseling necessary for providing the contraceptive method.

**"Medical necessity" for contraceptives may include**

- Severity of side effects
- Permanence and reversibility
- Ability to adhere to appropriate use of item or service

Plans may, however, impose reasonable medical management techniques within each of those methods and may impose cost-sharing on some items and services within a method to encourage use of a particular service or item. Also, if multiple services or items within a specific method are medically appropriate for an individual, the plan may use reasonable medical management techniques to determine which product to cover without cost-sharing.

> **Comment.** A plan may use cost-sharing to encourage the use of generic pharmacy items rather than brand name items. But if a plan does impose cost-sharing or medical management techniques, it must have an accessible, transparent and expedient exceptions process. Also, if a provider recommends a particular contraceptive service or item based on medical necessity, the plan must defer to the provider's determination and cover it without cost sharing. The effect of this latest guidance may require design changes to pharmacy coverage under a group health plan.

As some plans will likely require procedural changes, the departments have imposed an effective date. The guidance provided in this FAQ applies for plan years beginning on or after July 10, 2015 (60 days after the date the FAQs were issued).

## Sex-Specific Preventive Services

With respect to sex-specific preventive services, the FAQs explain that whether a particular preventive service is medically appropriate for an individual is to be determined by his or her attending provider. If the provider determines that the service is medically necessary, a plan must provide coverage, without cost-sharing, for the recommended preventive service regardless of sex assigned at birth, gender identity or gender of the individual as recorded by the plan (e.g., providing a mammogram or pap smear for a transgender man).

## Well-Woman Preventive Care

If a plan covers dependent children, it must provide, without cost-sharing, all of the recommended preventive services that apply to them. If an attending provider determines that well-woman preventive services are age- and developmentally-appropriate for a dependent (including preconception care and prenatal care), the plan must cover them.

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**Comment.** Plans that limit or deny maternity-related expenses for dependent children should review designs to ensure compliance. Many group health plans restrict access to such expenses.

### Colonoscopy Coverage

Under the USPSTF recommendations, a colonoscopy is a preventive screening procedure for colorectal cancer. When a colonoscopy is performed under this recommendation, a plan may not impose cost-sharing for the anesthesia services used for the procedure if the attending physician determines anesthesia is medically appropriate for the individual.

## In Closing

These FAQs serve as a reminder that the specifics of the preventive care service mandate continue to evolve. The FAQs provide needed clarity about several of the required preventive services. Except for the contraceptive coverage guidance, which is effective for plan years on or after July 10, the clarifications provided through this guidance appear to be immediately effective, and plan sponsors should review their programs to ensure compliance.

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