

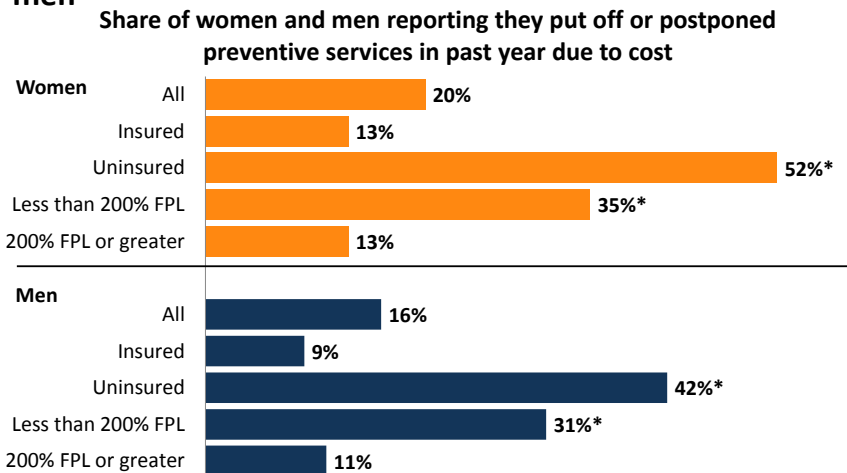
August 2015 | Fact Sheet

Preventive Services Covered by Private Health Plans under the Affordable Care Act

A key provision of the Affordable Care Act (ACA) is the requirement that private insurance plans cover recommended preventive services without any patient cost-sharing.¹ Research has shown that evidence-based preventive services can save lives and improve health by identifying illnesses earlier, managing them more effectively, and treating them before they develop into more complicated, debilitating conditions, and that some services are also cost-effective.² However, costs do prevent some individuals from obtaining preventive services (**Figure 1**). The coverage requirement aims to remove cost barriers.

Figure 1

Cost barriers to use of preventive services for women and men



NOTE: Among women and men ages 18-64. Federal Poverty Level (FPL) was \$19,530 for a family of three in 2013.*Indicates a statistically significant difference from Insured and 200% FPL or greater, $p < .05$.
SOURCE: Kaiser Family Foundation, 2013 Kaiser Women's Health Survey.

ACA REQUIREMENTS FOR COVERAGE OF PREVENTIVE SERVICES

Under Section 2713 of the ACA, private health plans must provide coverage for a range of preventive services and may not impose cost-sharing (such as copayments, deductibles, or co-insurance) on patients receiving these services.³ These requirements apply to all private plans – including individual, small group, large group, and self-insured plans in which employers contract administrative services to a third party payer – with the exception of those plans that maintain “grandfathered” status. In order to have been classified as “grandfathered,” plans must have been in existence prior to March 23, 2010, and cannot make significant changes to their coverage (for example, increasing patient cost-sharing, cutting benefits, or reducing employer contributions). In 2014, 26% of workers covered in employer sponsored plans were still in grandfathered plans,⁴ and it is expected that over time almost all plans will lose their grandfathered status.

The required preventive services come from recommendations made by four expert medical and scientific bodies – the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration’s (HRSA’s) Bright Futures Project, and HRSA and the Institute of Medicine (IOM) committee on women’s clinical preventive services. The requirement that insurers cover preventive services recommended by the USPSTF, ACIP, and Bright Futures program went into effect for non-grandfathered plans with plan-years beginning on or after September 23,

2010. The coverage requirements for women’s clinical preventive services became effective for plans starting on or after August 1, 2012. New or updated recommendations issued by these expert panels are required to be covered without cost-sharing beginning in the plan year that begins on or after exactly one year from the latest issue date.⁵ If a recommendation is changed during a plan year, an issuer is not required to make changes mid plan year, unless one of the recommending bodies determines that a service is discouraged because it is harmful or poses a significant safety concern.⁶ In these circumstances, federal guidance will be issued.⁷ Individual and small group plans in the new health insurance marketplaces are also required to cover an [essential health benefit \(EHB\) package](#) – in addition to the full range of preventive requirements described in this fact sheet. There is some crossover as several of the specific preventive services fall into the EHB categories. However, only preventive services recommended by one of the four groups discussed in this factsheet are covered without cost-sharing.

CLINICAL PREVENTIVE SERVICES FOR ADULTS AND CHILDREN

The ACA requires private plans to cover the following four broad categories of services for adults and children (summarized in **Tables 1** and **2**):

I. EVIDENCE–BASED SCREENINGS AND COUNSELING

Insurers now must cover evidence-based services for adults that have a rating of “A” or “B” in the current [recommendations of the United States Preventive Services Task Force \(USPSTF\)](#), an independent panel of clinicians and scientists commissioned by the Agency for Healthcare Research and Quality. An “A” or “B” letter grade indicates that the panel finds there is high certainty that the services have a substantial or moderate net benefit. The services required to be covered without cost-sharing include screening for depression, diabetes, cholesterol, obesity, various cancers, HIV and sexually transmitted infections (STIs), as well as counseling for drug and tobacco use, healthy eating, and other common health concerns. The issue date for a recommendation from USPSTF is considered to be the last day of the month in which it is published or otherwise released.

II. ROUTINE IMMUNIZATIONS

Health plans must also provide coverage without cost-sharing for immunizations that are recommended and determined to be for routine use by the [Advisory Committee on Immunization Practices \(ACIP\)](#), a federal committee comprised of immunization experts that is convened by the Centers for Disease Control and Prevention. These guidelines require coverage for adults and children and include immunizations such as influenza, meningitis, tetanus, HPV, hepatitis A and B, measles, mumps, rubella, and varicella. An ACIP recommendation is considered to be issued on the date that it is adopted by the Director of the CDC.

III. PREVENTIVE SERVICES FOR CHILDREN AND YOUTH

The ACA requires that private plans cover without cost-sharing the preventive services recommended by the [Health Resources and Services Administration’s \(HRSA’s\) Bright Futures Project](#), which provides evidence-informed recommendations to improve the health and wellbeing of infants, children, and adolescents. The [preventive services to be covered for children and adolescents](#) include some of the immunization and screening services described in the previous two categories, behavioral and developmental assessments, iron and fluoride

supplements, and screening for autism, vision impairment, lipid disorders, tuberculosis, and certain genetic diseases.

IV. PREVENTIVE SERVICES FOR WOMEN

The recommendations issued by USPSTF, ACIP, and Bright Futures predate the ACA. In addition to these services, the ACA authorized the federal Health Resources and Services Administration (HRSA) to [make additional coverage requirements for women](#). Based on recommendations by a committee of the Institute of Medicine (IOM),⁸ federal regulations require new private plans to cover additional preventive services without cost-sharing for women, including well-woman visits, all FDA-approved contraceptives and related services, broader screening and counseling for STIs and HIV, breastfeeding support and supplies, and domestic violence screening.

COVERAGE RULES AND IMPLEMENTATION CHALLENGES

While the ACA aims to reduce the burden of cost and increase use of preventive services, there are certain rules that both plans and policy holders must follow. There are circumstances, however, under which insurers may charge copayments and use other forms of cost-sharing when paying for preventive services. These include:

- If the office visit and the preventive service are billed separately, cost-sharing cannot be charged for the preventive service but the insurer may still impose cost-sharing for the office visit itself.
- If the primary reason for the visit is not the preventive service, patients may have to pay for the office visit.
- If the service is performed by an out-of-network provider when an in-network provider is available to perform the preventive service, insurers may charge patients for the office visit and the preventive service. However, if an out-of-network provider is used because there is no in-network provider able to provide the service then cost-sharing cannot be charged.
- If a treatment is given as the result of a recommended preventive service, but is not the recommended preventive service itself, cost-sharing may be charged.⁹

The Public Health Service (PHS) Act and federal regulations also allow plans to use “reasonable medical management” techniques to determine the frequency, method, treatment, or setting for a preventive item or service to the extent it is not specified in a recommendation or guideline.¹⁰ While there is no formal regulatory definition or parameters for reasonable medical management, medical management techniques are typically used by plans to control cost and utilization of care or comparable drug use. For example, plans can impose limits on number of visits or tests if unspecified by a recommendation, cover only generics or selected brands of pharmaceuticals, or require prior authorization to acquire a preferred brand drug. If a plan makes any material modifications that would affect the content of the plan’s Summary of Benefits and Coverage (SBC) during the plan year, the plan must notify enrollees of the change at least 60 days before it takes effect.¹¹

The combination of these caveats and limitations has resulted in many questions about how plans should implement the preventive services policy. In particular, questions have arisen about the frequency, range of methods that can be used for certain services, and the types of providers that are subject to the policy. The Departments of Health and Human Services, Labor, and Treasury jointly issue memos as [“Frequently Asked](#)

[Questions](#)” specifically on implementation of the Affordable Care Act which provide additional clarification on different aspects of coverage of preventive services:

- *Colon cancer screening* - Screening for colorectal cancer using colonoscopies receives an “A” rating from the USPSTF, yet there have been some cases of insured asymptomatic patients being charged unexpected cost-sharing for anesthesia and polyp removal during screening colonoscopies.¹² The federal government has clarified that insurers cannot impose cost sharing for medically necessary anesthesia services and polyp removal performed in connection with a preventive colonoscopy in asymptomatic individuals.^{13, 14}
- *Aspirin for the prevention of cardiovascular disease* - Over the counter medications are provided without cost-sharing only with a prescription.
- *Breastfeeding* – While the USPSTF recommends prenatal and postnatal breastfeeding interventions, HRSA guidelines specifically incorporate lactation support, counseling and equipment rental without cost-sharing. Federally-issued FAQs clarified that this coverage should last as long as the woman is breastfeeding.
- *Well-woman visits* – The HRSA clinical preventive services for women include coverage for at least one well-woman preventive care visit for adult women, including preconception and prenatal care, yet controversy exists with the number of well-woman visits that are permitted per year. The government has clarified that *multiple well-woman* visits may be required to fulfill all necessary preventive services and should be provided without cost-sharing as needed, determined by clinical expertise. Federally issued guidance notes that all dependents, including sons and daughters, must also receive all preventive services coverage as applicable, without cost-sharing. The FAQ’s specifically outline that dependent daughters also receive preconception and prenatal care as part of a well-woman visit without cost sharing.
- *Testing and medications for the risk reduction of breast cancer* – Federal guidance reinforces the USPSTF recommendation that women with family history of breast, ovarian, or peritoneal cancer should be screened for BRCA-related cancer, and those with positive results should receive genetic counseling and genetic BRCA testing when appropriate. As long as the woman has not specifically been diagnosed with BRCA-related cancer in the past, genetic screening, counseling and testing should be covered without cost sharing when the services are medically appropriate and recommended by her provider. USPSTF also recommends the provision of chemo-preventive medications for women deemed to be at high risk. As such, risk-reducing medications, such as tamoxifen or raloxifene, must be covered without cost sharing as prescribed to women who are at increased risk for breast cancer and at low risk for adverse medication effects.¹⁵
- *Special populations* - In the cases where recommendations for preventive services, counseling, and immunizations apply only to a certain population, such as “high risk” individuals, the government clarified that it is up to the health care provider to determine whether a patient belongs to the population in consideration.¹⁶ An individual’s sex assigned at birth or gender identity also cannot limit them from a recommended preventive service that is medically appropriate for that individual; for example, a transgender man who has breast tissue or an intact cervix and meets other requirements for

mammography or cervical cancer screening must receive those services without cost sharing regardless of sex at birth.

- *Contraceptive coverage* – Federal clarification states that issuers and plans must cover the full range of prescribed contraceptive methods for women, currently at 18 distinct methods, as outlined in the FDA’s [Birth Control Guide](#). Issuers may not limit coverage to any contraceptive method, such as oral contraceptives, but must provide at least one version of each [FDA-approved contraceptive method without cost sharing](#). Insurers may use reasonable medical management within a method, however, to limit coverage to generic drugs and can impose cost-sharing for equivalent branded drugs. Plans are required to have an accessible and timely “waiver” process for patients who have a medical need for contraceptives otherwise subject to cost-sharing. In addition, federal rules regarding contraceptive coverage specifically exempt or accommodate certain employers who believe that the requirement violates their religious rights.¹⁷

IMPACT OF THE PREVENTIVE SERVICES RULES

The federal HHS Assistant Secretary for Planning and Evaluation (ASPE) estimates that approximately 137 million people (55.6 million women, 53.5 million men, and 28.5 million children) have received no-cost coverage for preventive services since the policy went into effect.¹⁸ While the number of individuals who have gained coverage for no-cost preventive services is large, public awareness of the preventive services requirement is relatively low. In March 2014, three and half years after the rule took effect, less than half the population (43%) reported they were aware that the ACA eliminated out-of-pocket expenses for preventive services.¹⁹ As awareness of the benefit grows and the share of people in grandfathered plans reduces, very few privately insured individuals will have financial barriers to clinical preventive care. The big question remains: will this new benefit increase use of preventive services and, ultimately, what will be the law’s impact on the public’s health and health care costs.

Table 1: Summary of Selected Preventive Services for Adults Covered by Non-Grandfathered Private Plans without Cost Sharing

Cancer	Chronic Conditions	Immunizations	Health Promotion	Pregnancy-Related**	Reproductive Health
• Breast cancer - Mammography (women 40+*) - Genetic (BRCA) screening and counseling (women at high risk) - Preventive medication (women at high risk) • Cervical cancer - Pap testing (women 21+ with cervix) - HPV DNA testing[‡] (women 30–65 with normal pap results) • Colorectal cancer - Fecal occult blood testing, sigmoidoscopy, and/or colonoscopy. (adults 50– 75) • Lung cancer screening - Annual tomography (adults 55– 80 with history) • Skin cancer - Counseling (adults 18– 24)	• Abdominal aortic aneurysm screening (men 65– 75 who have ever smoked) • Cardiovascular health - Hypertension screening - Blood pressure - Lipid disorders screenings (high risk women 20+; at risk men 20– 35; all men 35+) - Aspirin (men 45– 79; women 55– 79) - Behavioral Counseling (overweight or obese adults with CVD risk factors) • Diabetes (Type 2) screening (adults with elevated blood pressure) • Depression screening (adults when follow up supports available) • Hepatitis B screening (adults at high risk for infection) • Hepatitis C screening (high risk adults; one time screening for adults born between 1945 and 1965) • Obesity Screening and Management (all adults via body mass index (BMI)) - Referral for intervention for adults ≥ BMI of 30 kg/m² • Osteoporosis screening (all women 65+; high risk women <60)	• Haemophilus influenzae type b (adults 18+ with risk factors) • Hepatitis A (adults with risk factors) • Hepatitis B (adults with risk factors) • HPV (women 18– 26 and men 18– 21 not previously vaccinated; at risk men 22– 26) • Influenza (yearly) • Meningococcal (adults 18+ with risk factors) • Measles, Mumps and Rubella (adults 18– 49; 50+ with risk factors) • Pneumococcal (adults 19– 64 with risk factors; adults 65+) • Td booster, Tdap • Varicella • Zoster (adults 60+)	• Alcohol misuse screening and counseling (risk assessment all adults) • Fall Prevention Counseling and Preventive Medication (community-dwelling adults 65+) • Intimate partner violence screening, counseling[‡] (women) • Tobacco counseling and cessation interventions • Well-woman visits[‡] (women 18– 64; visits for recommended preventive services, preconception care, and/or prenatal care)	• Alcohol misuse screening and counseling • Breastfeeding supports - Counseling - Consultations with trained provider[‡] - Equipment rental[‡] • Folic acid supplements (women with reproductive capacity) • Gestational diabetes screenings[‡] (after 24 weeks gestation) • Iron deficiency anemia screening • Preeclampsia preventive medicine (pregnant women at high risk) • Low-dose aspirin (at risk women after 12 weeks of gestation) • Screenings for pregnant women - Hepatitis B - Chlamydia (women ≤24 years; older women at risk) - Gonorrhea - Syphilis - Bacteriurea • Tobacco counseling and cessation interventions	• Contraception (all women with reproductive capacity)[‡] * - All FDA-approved contraceptive methods as prescribed - Sterilization procedures - Patient education and counseling - Services related to follow-up, management of side effects, and device removal • Screenings - Chlamydia (sexually active women ≤24 years old, older women at risk) - Gonorrhea ((sexually active women ≤24 years old, older women at risk) - Syphilis (adults at high risk) - HIV (adults 15– 65; at-risk younger adolescents and older adults) • STI and HIV counseling (adults at high risk; all sexually-active women[‡])

Notes: Unless noted, applicable age for the recommendations is age 18+. Pregnancy-related applies to pregnant women. Age ranges are meant to encompass the broadest range possible. Each service may only be covered for certain age groups or based on risk factors. *The ACA defines the recommendations of the USPSTF regarding breast cancer services to “the most current other than those issued in or around November 2009.” Thus, coverage for mammography is guided by the 2002 USPSTF guideline. **Services in this column apply to all pregnant or lactating women, unless otherwise specified. ***Certain religious employers exempt from this requirement. [‡]Recommendation from HRSA Women’s Preventive Services; coverage for these services without cost sharing in “non-grandfathered” plans began August 1, 2012. Coverage without cost sharing for all other services went into effect Sep. 23, 2010.

Sources: CMS, [Affordable Care Act Implementation FAQ’s Set 18](#). CMS, [Preventive Health Services for Adults](#). More information about each of the items in this table, including details on periodicity, age, risk factors, and specific tests and procedures are available at the following websites: [USPSTF](#); [ACIP](#); [HRSA Women’s Preventive Services](#).

Table 2: Summary of Selected Preventive Services for Children Covered by Non-Grandfathered Private Plans without Cost Sharing

Chronic Conditions	Immunizations	Health Promotion	Reproductive Health	Development and Behavioral Health
• Cardiovascular health - Blood pressure (screening for at risk newborn children – 3 years; children 3 years+) - Lipid disorders screenings (children 2 years+ risk assessment/ screening) • Depression screening (adolescents 11 years+) • Hepatitis B screening (adolescents at high risk for infection) • Skin cancer counseling (children 10 years+) • Obesity - Screening (children 2 years+ via body mass index (BMI)) - Counseling and behavioral interventions (obese children 6 years+)	• DTaP (children 2 months– 6 years) • Haemophilus influenzae type b (children 2 months – 4 years) • Hepatitis A (children 1 year+; 2 years+ with risk factors) • Hepatitis B (at birth; then newborn+) • HPV (children 11 years+) • Inactivated Poliovirus (children 2 months+) • Influenza (yearly) (children 6+ months+) • Meningococcal (children 11 years+; 2 months+ with risk factors) • Measles, Mumps and Rubella (children 1 year+) • Pneumococcal - Pneumococcal conjugate (children 2 months – 4 years; 5 years+ with risk factors) - Pneumococcal polysaccharide (children 2 years+ with risk factors) • Td booster, Tdap (children 7 years+) • Varicella (children 1 year+) • Rotavirus (children 2– 6 months)	• Anemia screening, supplements (children 6 months+ iron supplements for high risk 6 – 12 months) • Dental caries prevention - Fluoride varnish (infants and children at age of primary teeth eruption) - Fluoride supplements (children 6+ months without fluoride in water source) • Gonorrhea prophylaxis treatment (newborn) • History and physical exams (prenatal+) • Measurements: - Length/height and weight (children newborn– adolescence) - Head circumference, weight for length (newborn – 2 years) - Body mass index (BMI) (children 2 years+) - Blood pressure (risk assessment at birth; children 3 years+) • Oral health: risk assessment, referral to dental home (children 6 months – 6 years) • Screenings - Blood screening (newborn– 2 months) - Critical congenital health defect (newborn) - Lead screening (children risk assessment and/or test 6 months – 6 years) - Metabolic/hemoglobin, phenylketonuria, sickle cell, congenital hypothyroidism screenings (newborn+) - Tuberculin (children risk assessment 1 month+) • Tobacco counseling and cessation interventions (children 5 years– adolescence) • Vision and hearing screenings/assessment (children newborn+)	• Contraception (all women with reproductive capacity)^{§*} - All FDA-approved contraceptive methods as prescribed - Sterilization procedures - Patient education and counseling - Services related to follow-up, management of side effects, and device removal • STI and HIV counseling (sexually-active adolescents) • Screenings - Chlamydia (sexually active females) - Gonorrhea (sexually active females) - HIV (adolescents and at risk children; screening ages 16– 18) - STIs (risk assessment for adolescents; screening ages 16– 18)	• Alcohol misuse screening and counseling (risk assessment adolescents 11 years+) • Autism screening: (infants 18– 24 months) • Developmental screenings and surveillance (newborn+) • Psychosocial/ behavioral assessment (newborn+)

Notes: Age ranges are meant to encompass the broadest range possible, up to age 21. Each service may only be covered for certain age groups or based on risk factors. For specific details on recommendations, please consult the websites listed below. *Certain religious employers exempt from this requirement. [§]Recommendation from HRSA Women's Preventive Services; coverage for these services without cost sharing in "non-grandfathered" plans began August 1, 2012. Coverage without cost sharing for all other services went into effect Sep. 23, 2010.

Sources: CMS, [Affordable Care Act Implementation FAQ's Set 18](#). CMS, [Preventive health services for children](#). More information about each of the items in this table, including details on periodicity, age, risk factors, and specific tests and procedures are available at the following websites: [USPSTF](#); [Bright Futures and American Academy of Pediatrics](#); [ACIP](#); [HRSA Women's Preventive Services](#).

ENDNOTES

¹ [The Patient Protection and Affordable Care Act, Sec. 2713, Coverage of Preventive Services.](#)

² Maciosek, Michael V. "Greater Use Of Preventive Services In U.S. Health Care Could Save Lives At Little Or No Cost." *Health Affairs* 29.9 (2010): 1656-660.

³ Note that the rules described in this fact sheet apply to private insurers, self-insured employer plans, and are separate from preventive requirements for public programs like Medicare or Medicaid.

⁴ Kaiser Family Foundation, Health Research and Educational Trust, [Employer Health Benefits 2014 Annual Survey](#).

⁵ The final issue date for new or updated recommendations varies by recommending body. Recommendations are considered to be issued on the last day of the month on which the USPSTF publishes or releases the recommendation; recommendations from ACIP are considered issued on the date it is adopted by the Director of the CDC; and a recommendation or guideline supported by HRSA is considered to be issued on the date on which it is accepted by the Administrator of HRSA or, if applicable, adopted by the Secretary of HHS. [Federal Register, Vol. 80, NO. 134, July 14, 2015.](#)

⁶ These circumstances include downgrade of a USPSTF service from a rating of “A” or “B” to “D” (which means that USPSTF has determined that there is strong evidence that there is no net benefit, or that the harms outweigh the benefits, and therefore discourages the use of this service), or a service is the subject of a safety recall or otherwise determined to pose a significant safety concern by a federal agency authorized to regulate that item or service.

⁷ [Federal Register, Vol. 80, NO. 134, July 14, 2015.](#)

⁸ Institute of Medicine, [Clinical Preventive Services for Women: Closing the Gaps](#), July 19, 2011.

⁹ [Federal Register, Vol. 75, NO. 137, July 18, 2010.](#)

¹⁰ [Federal Register, Vol. 75, NO. 137, July 18, 2010.](#)

¹¹ [Federal Register, Vol. 80, NO. 134, July 14, 2015.](#)

¹² KFF, [Coverage of Colonoscopies under the Affordable Care Act’s Prevention Benefit](#).

¹³ Centers for Medicare and Medicaid Services, [Affordable Care Act Implementation FAQs – Set 26](#).

¹⁴ CMS, [Affordable Care Act Implementation FAQs – Set 12](#).

¹⁵ Department of Labor, [FAQs about Affordable Care Act Implementation \(Part XVIII\) and Mental Health Parity Implementation](#).

¹⁶ CMS/CCIIO, [Affordable Care Act Implementation FAQ’s Set 12](#).

¹⁷ The ACA requires that all FDA-approved contraceptive methods and services, as prescribed by a clinician, must be covered without cost-sharing. At least one version of each method must be covered, including brand-name versions if no generic option is available. However, religious institutions defined as “houses of worship” are exempt from the requirement. Women covered by these plans do not receive contraceptive coverage. Religiously affiliated nonprofit organizations and closely held for profit employers that object to contraceptives are eligible for an accommodation, and do not have to pay for contraceptive coverage offered by their employer-sponsored plans. In these cases, the insurer or third party administrator of these plans must pay for the cost of coverage, assuring that women covered by these plans receive contraceptive coverage. For more information see [“How Does Where You Work Affect Your Contraceptive Coverage?”](#)

¹⁸ ASPE, [The Affordable Care Act is Improving Access to Preventive Services for Millions of Americans](#), May 14, 2015

¹⁹ KFF, [Kaiser Health Tracking Poll](#), March 2014.