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BENEFIT NEWS BRIEFS

New ACA FAQs Address Preventive Services Required To Be Covered by Non-Grandfathered Plans

On May 11, 2015, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) published Set XXVI of the *Affordable Care Act (ACA)* Frequently Asked Questions (FAQs) concerning coverage of preventive services required by **non-grandfathered** group health plans, including multiemployer group health plans. A specially prepared copy with an added table of contents is available by "*clicking here*."

The relevant portion of the *ACA* (Section 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relate to coverage of preventive services and require **non-grandfathered** group health plans to provide benefits for certain preventive services without the imposition of *cost-sharing* requirements (*copayment, coinsurance, or deductible*) with respect to these preventive services.

These preventive services are:

- Evidenced-based items or services that have in effect 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, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, 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.

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You will recall that if a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a recommended preventive service the non-grandfathered plan may use reasonable medical management techniques to determine any such coverage limitations.

The Seven Non-Grandfathered Plan Preventive Services FAQs

Set XXVI contains 7 FAQs on preventive services that address the following topics:

- *Coverage of BRCA Testing*
- *Coverage of Food and Drug Administration (FDA)-approved Contraceptives*
- *Coverage of Sex-specific Recommended Preventive Services*
- *Coverage of Well-woman Preventive Care for Dependents*
- *Coverage of Colonoscopies Pursuant to USPSTF Recommendations*

NOTE: The FAQs on contraceptives are a clarification of prior FAQs and are applicable the first Plan Year beginning on or after July 10, 2015 (the first Plan Year beginning 60 days after the date of these May 11 FAQs).

The following is a summary of the answers to the FAQs. A chart showing each FAQs and the short answer is available by "*clicking here*."

Coverage of BRCA Testing (FAQ 1)

A non-grandfathered plan must cover without cost sharing recommended genetic counseling and BRCA genetic testing for a woman who has not been diagnosed with BRCA-related cancer but who previously had breast cancer, ovarian cancer or other cancer.

Coverage of FDA-approved Contraceptives (FAQs 2-4)

FAQ 2 clarifies that a non-grandfathered plan that covers *some* forms of oral contraceptives, *some* types of IUDs, and *some* types of diaphragms without cost sharing, but *completely* excludes other forms of contraception will NOT comply with PHS Act Section 2713 and its implementing regulations. The FAQs clarify that plans must cover without cost sharing the full range of FDA-identified methods. Thus, plans must cover without cost sharing *at least one form of contraception* in each method that is identified by the FDA.

The FDA currently has identified *18 distinct methods* of contraception for women. The contraceptive methods for women currently identified by the FDA include: (1) sterilization surgery for women; (2) surgical sterilization implant for women; (3) implantable rod; (4) IUD copper; (5) IUD with progestin; (6) shot/injection; (7) oral contraceptives (combined pill); (8) oral contraceptives (progestin only); (9) oral contraceptives extended/continuous use; (10) patch; (11) vaginal contraceptive ring; (12) diaphragm; (13) sponge; (14) cervical cap; (15) female condom; (16) spermicide; (17) emergency contraception (Plan B/Plan B One Step/Next Choice); and (18) emergency contraception (Ella).

However, a non-grandfathered plan has some flexibility and generally may use reasonable medical management techniques and impose cost sharing (including full cost sharing) on some items or services in a particular method to encourage an individual patient to use specific services or FDA-approved items *within the chosen contraceptive method*.

FAQ 3 addressed the situation where multiple services and FDA-approved items *within a contraceptive method* are medically appropriate for an individual patient. In such cases, the non-grandfathered plan may use reasonable medical management techniques to determine which specific products to cover without cost sharing with respect to that individual. However, if an individual's medical provider recommends a particular service or FDA-approved item based on a determination of medical necessity with respect to that individual, the plan must cover that service or item without cost sharing.

FAQ 4 clarifies that if a non-grandfathered plan covers oral contraceptives (such as the extended/continuous use contraceptive pill) it cannot impose cost sharing on all items and services within other FDA-identified hormonal contraceptive methods (such as the vaginal contraceptive ring or the contraceptive patch).

Coverage of Sex-specific Recommended Preventive Services (FAQ 5)

This FAQ states that non-grandfathered plans cannot limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity or recorded gender. The FAQ explains whether a sex-specific recommended preventive service that is required to be covered without cost sharing is medically appropriate for a particular individual is determined by the individual's attending provider.

Therefore, where the individual's medical provider determines that a recommended preventive service is medically appropriate for the individual – such as, for example, providing a mammogram or pap smear for a transgender man who has residual breast tissue or an intact cervix – and the individual otherwise satisfies the criteria in the relevant recommendation or guideline as well as all other applicable coverage requirements, the plan must provide coverage for the recommended preventive service, without cost sharing, regardless of sex assigned at birth, gender identity, or gender of the individual otherwise recorded by the plan.

Coverage of Well-woman Preventive Care for Dependents (FAQ 6)

Non-grandfathered plans are not required to cover dependents, but if a plan does cover dependent children (up to age 26), the plan is required to cover without cost sharing for recommended women's preventive care services for such dependent children.

The FAQ clarifies that such dependent children must be provided the full range of recommended preventive services applicable to them (e.g., *for their age group*) without cost sharing and subject to reasonable medical management techniques.

Well-woman visits for adult women include preconception care and many services necessary for prenatal care.

More information on well-woman visits can be found online at these websites:

- http://www.hrsa.gov/womensguidelines/
- http://www.dol.gov/ebsa/faqs/faq-aca12.html
- http://www.hhs.gov/healthcare/facts/factsheets/2011/08/womensprevention08012011a.html

Coverage of Colonoscopies Pursuant to USPSTF Recommendations (FAQ 7)

This FAQ states that if a colonoscopy is scheduled and performed as a preventive screening procedure for colorectal cancer pursuant to the USPSTF recommendation, the non-grandfathered plan may not impose cost sharing with respect to anesthesia services performed in connection with the preventive colonoscopy.

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