**Coverage of Preventive Health Services**

**Summary:** Requires all plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention (CDC), and certain child preventive services recommended by the Health Resources and Services Administration, without any cost-sharing.

**Status updates:**
- On July 20, 2011, the Institute of Medicine (IoM) issued its report entitled “Clinical Preventive Services for Women: Closing the Gaps,” which reviews the existing list of preventive services for women's health, examines additional screenings and services that have been shown to be effective for women, recommends preventive services and screenings that should be considered for inclusion in the guidelines, as well as a process for the Department of Health and Human Services to coordinate regular updates to the preventive service lists over time.
- On August 1, 2011, the Department of Health and Human Services (HHS) announced that health plans must cover, for policies with plan years beginning on or after August 1, 2012, the following preventive services for women without cost sharing, including: well-woman visits; screening for gestational diabetes; human papillomavirus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies, and counseling; and domestic violence screening and counseling.
- On August 3, 2011, the Departments of HHS, Labor, and Treasury announced through the Federal Register a limited exception to the contraception requirement for religious employers.
- On September 8, 2011, HHS announced that over 18.9 million people enrolled in traditional Medicare have used preventive services with no cost to them.

**Next steps:**
- July 14, 2010 – The Departments of Health and Human Services (HHS), Labor, and the Treasury released the new regulations. On July 19, those regulations were formally published in the Federal Register.
- September 19, 2010 – Comment period closes.
- September 30, 2010 – Regulations effective.
- October 8, 2010 -- The Department of Labor (DoL) issued a frequently asked questions (FAQ) regarding health reform and touched upon issues related to preventive health services. Specifically, DoL clarified that "the interim final regulations regarding preventive health services provide that if a recommendation or guideline for a recommended preventive health service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management
techniques (which generally limit or exclude benefits based on medical necessity or medical appropriateness using prior authorization requirements, concurrent review, or similar practices) to determine any coverage limitations under the plan. Thus, to the extent not specified in a recommendation or guideline, a plan or issuer may rely on the relevant evidence base and these established techniques to determine the frequency, method, treatment, or setting for the provision of a recommended preventive health service.”

- November 16, 2010 -- Institute of Medicine’s first meeting of the Committee on Preventive Services for Women.
- November 29, 2010 -- While nominations are welcome at any time, to be considered for appointment in 2011, complete nominations must be received by November 29, 2010.
- December 23, 2010 -- The Department of Labor’s Employee Benefits Security Administration, in coordination with the Departments of Health and Human Services and Treasury, provided new guidance, presented in the form of frequently asked questions (FAQs). The FAQs specifically addressed copayments for colorectal cancer screenings.
- December 28, 2010 -- The Departments of Treasury, Labor and Health and Human Services issued a request for information regarding value-based insurance design, as it relates to preventive health services. Comments are due by February 28, 2011.
- Late December 2010 -- Institute of Medicine announced the second meeting of the Committee on Preventive Services for Women on January 12, 2011.
- January 12, 2011 -- Second meeting of the Institute of Medicine’s Committee on Preventive Services for Women.
- February 28, 2011 -- Comments due to the December 28th request for information.
- May 20, 2011 -- A group of medical societies and patient advocacy groups urged the Agency for Healthcare Research and Quality to restructure the US Preventive Services Task Force.
- July 20, 2011 -- IoM issued its report entitled “Clinical Preventive Services for Women: Closing the Gaps.”
- August 1, 2011 -- HHS announced new preventive services for women covered by this provision.
- August 3, 2011 -- Departments of HHS, Labor, and Treasury announced through the Federal Register a limited exception to the contraception requirement for religious employers.
- September 8, 2011 -- HHS announced that over 18.9 million people enrolled in traditional Medicare have used preventive services with no cost to them.
- January 18, 2012 -- New bone scan recommendations must be covered by plan or policy years beginning after this date.
- August 1, 2012 -- New women’s preventive services must be covered by plan or policy years beginning after this date.

**Additional information:**

- September 8, 2011 HHS information regarding preventive health services among traditional Medicare beneficiaries -- [http://www.cms.gov/NewMedia/02_preventive.asp](http://www.cms.gov/NewMedia/02_preventive.asp)
• August 1, 2011 HHS fact sheet on women’s preventive services coverage --
• July 20, 2011 IoM women’s preventive services report --
  [http://www.iom.edu/sitescore/content/Home/Activities/Women/PreventiveServicesWo
_campaign=07.11+IoM+News&utm_content=IoM%20Newsletter&utm_term=Commercial]
• May 20 press release regarding restructuring --
:uspstf-needs-overhaul-groups-say]
• U.S. Preventive Services Task Force recommendation regarding bone scans –
  [http://www.uspreventiveservicestaskforce.org/uspstf/uspsoste.htm]
• Institute of Medicine’s announcement regarding the January 12, 2011 meeting of the
  Committee on Preventive Services for Women --
:utm_medium=email&utm_source=Institute%20of%20Medicine&utm_campaign=12.30.10+Meet
ing+Alert&utm_content=Meetings%20%20Events&utm_term=Commercial]
• Registration for the January 12, 2011 Institute of Medicine meeting --
  [http://www.surveygizmo.com/s3/435311/Preventive‐Services‐for‐Women]
• December 28 Federal Register notice (request for information regarding value‐based
• December 23 Frequently Asked Questions (FAQs) –
  [http://www.dol.gov/ebsa/faqs/faq‐aca5.html]
• AHRQ’s November 10 request for nominations to the U.S. Preventive Health Services
• DOL’s October 8 FAQ – [http://www.dol.gov/ebsa/faqs/faq‐aca2.html]
• Institute of Medicine’s information regarding the November 16, 2010 meeting of the
  Committee on Preventive Services for Women --
• Interim Final Regulations released July 14--
  [http://www.healthcare.gov/center/regulations/prevention/regs.html] and
• HHS July 14 press release --
• HHS summary -- [http://www.healthcare.gov/law/about/provisions/services/index.html]
• Complete list of recommendations and guidelines that are required to be covered under
  these interim final regulations –
• U.S. Preventive Services Task Force -- [http://www.ahrq.gov/clinic/uspstfix.htm]
• Kaiser Family Foundation fact sheet on topic --
  [http://www.kff.org/healthreform/upload/8219.pdf]
• Annals of Internal Medicine article regarding the USPHSTF recommendations and coverage
  under Medicare -- [http://www.annfammed.org/cgi/reprint/9/1/44]
• Advisory Committee for Immunization Practices --
  [http://www.cdc.gov/vaccines/recs/acip/default.htm]
• Health Resources and Services Administration (HRSA) Bright Futures recommendations for
  pediatric preventive care --
  [http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20
20101107.pdf]
- Recommendations from the Secretary's Advisory Committee on Heritable Disorders on Newborns and Children --
  http://www.hrsa.gov/heritabledisorderscommittee/SACHDNC.pdf

Long summary:

PHS Act sec. 2713. Coverage of Preventive Health Services (as modified by sec. 10101).
Requires that at a minimum, a group health plan and an issuer offering group or individual
coverage provide coverage for and not impose any cost sharing requirements for: (1) evidence-
based items or services that have in effect a rating of "A" or "B" in the current recommendations of
the U.S. Preventive Services Task Force (USPSTF); (2) immunizations that have in effect a
recommendation from the Advisory Committee on Immunization Practices of the Centers for
Disease Control and Prevention with respect to the individual involved; (3) with respect to infants,
children, and adolescents, evidence-informed preventive care and screenings provided for in the
comprehensive guidelines supported by the Health Resources and Services Administration; (4)
with respect to women, such additional preventive care and screening services not described
in paragraph (1) above as provided for in comprehensive guidelines supported by the Health
Resources and Services Administration for this purpose; and (5) for purposes of this Act and for
purposes of any other provisions of law, the current recommendations of the USPTF regarding
breast cancer screening, mammography, and prevention shall be considered the most current other
than those issued in or around November 2009. States that this provision is not meant to prohibit
a plan or issuer from providing coverage for services in addition to those recommended by the
USPSTF or from denying coverage for services that are not recommended by the Task Force.

Interval. Requires the Secretary to establish a minimum interval, of no less than 1 year, between
the date on which a recommendation or a guideline is issued and the plan year with respect to
which the requirement is effective.

Value-based insurance design. The Secretary may develop guidelines to permit a group health
plan and an issuer offering group or individual coverage to utilize value-based insurance designs.

Summary of the Regulations:

Immunizations. For immunizations, a recommendation of the Advisory Committee is considered
to be "in effect" after it has been adopted by the Director of the Centers for Disease Control and
Prevention. A recommendation is considered to be for routine use if it appears on the Immunization
Schedules of the Centers for Disease Control and Prevention.

Preventive care for children. Clarified through a separate document that "comprehensive
guidelines supported by the Health Resources and Services Administration" includes HRSA’s Bright
Futures recommendations as well as recommendations from the Secretary's Advisory Committee
on Heritable Disorders on Newborns and Children.

Preventive care for women. For evidence-informed preventive care and screening for women, the
Department of Health and Human Services expects to issue them no later than August 1, 2011.

Separate billing for office visits. The interim final rule (IFR) clarifies the cost-sharing
requirements when a recommended preventive service is provided during an office visit. First, if a
recommended preventive service is billed separately (or is tracked as individual encounter data
separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with
respect to the office visit. Second, if a recommended preventive service is not billed separately (or is
not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit. Finally, if a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. The reference to tracking individual encounter data was included to provide guidance with respect to plans and issuers that use capitation or similar payment arrangements that do not bill individually for items and services.

**Exceptions.** The IFR clarifies that cost-sharing can still be imposed when (1) the recommended preventive services is delivered by an out-of-network provider, (2) for some preventive services if the recommendation or guideline for such services does not specify the frequency, method, treatment, or setting for the provision of that service after the plan or issuer uses reasonable medical management techniques to determine any coverage limitations, and (3) an item or service ceases to be a recommended preventive service, although other provisions may apply.

**Interval.** Sets the interval for implementing the guidelines at one year, the statutory maximum. Coverage must be provided for plan years (in the individual market, policy years) beginning on or after the later of September 23, 2010, or one year after the date the recommendation or guideline is issued. Thus, recommendations and guidelines issued prior to September 23, 2009 must be provided for plan years (in the individual market, policy years) beginning on or after September 23, 2010.

**Value-based insurance design.** The IFR does not address this issue.

**Legislative text:**

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"SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.
(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—
(1) evidence-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;
(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.
(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.
Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.
(b) INTERVAL.—
(1) IN GENERAL.—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.
(2) MINIMUM.—The interval described in paragraph (1) shall not be less than 1 year.
(c) VALUE-BASED INSURANCE DESIGN.—The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.
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