COMPLIANCE ALERT

Coverage of Preventive Services Without Cost-Sharing

EPIC Insurance Brokers & Consultants

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Quick Facts

- The Affordable Care Act's (ACA's) Public Health Service Act (PHSA) §2713 contains a list of items considered preventive healthcare which must be covered with no cost-sharing.
- The list continues to be updated by designated departments/agencies based on newly available medical treatments and best practices.
- In 2020, the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) required additional diagnostic testing and related services with no cost-sharing.

Background

Non-grandfathered group health plans are required to provide the following preventive services without imposing any copayments, coinsurance, deductibles, or other cost-sharing requirements:

- 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 (USPSTF) with respect to the individual involved;
- **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 infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- Evidence-informed preventive care and screening are provided for in the comprehensive guidelines supported by **HRSA for women**.

Access to Care

Plans that maintain a network of providers are not required to cover services received out-of-network. In addition, plans may use "reasonable medical management techniques" to help control costs such as requiring preauthorization or providing coverage for generic instead of brand name drugs, however, such techniques may only be used when the applicable recommendation or guideline does not specify the frequency, method, treatment, or setting for a particular preventive service – in other words, any medical management techniques may not conflict with the recommendations or guidelines.

In addition, plans 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.

Recommendations Are Continuously Changing

As noted above, the lists of items that are considered preventive continue to be updated by designated departments/agencies over time based on newly available medical treatments and best practices.

Generally, if a new service or item is added to the list of recommended preventive services, plans are required to cover it beginning with the first plan year starting on or after the date the recommendation is made. Further, services that constitute a recommended preventive service on the first day of a plan year must generally be covered through the end of the plan year.

COVID-19 Preventive Services

In 2020, the (FFCRA) put in place a requirement that plans cover diagnostic testing and related services with no cost-sharing. This differed a bit from the standard **ACA preventive coverage** requirements, in that it applied to grandfathered plans and prohibited use of prior authorizations or medical management. Additionally, the CARES Act required that plans subject to the ACA's preventive services mandate (i.e., non-grandfathered plans) cover "qualifying coronavirus preventive service," which refers to "any item, service, or **immunization** that is intended to prevent or mitigate coronavirus disease" that: (i) has a rating of 'A' or 'B' in the current recommendations of the USPSTF; or (ii) is recommended by ACIP and adopted by the Director of the CDC, even if not listed for routine use on the CDC Immunization Schedules." Note that in this case, the requirement to cover the recommended service applies 15 business days after the recommendation (instead of on the plan year beginning on the year after the recommendation). Additionally, coverage must be provided for out-of-network services.

Summary

Employers and plan administrators should be sure to check the updated lists of recommended items and services at least annually to ensure that their plan is not imposing cost-sharing on anything that has been newly added. In addition, group health plans are required to ensure that participants are appropriately notified of the preventive items and services covered without cost-sharing by the plan by including a statement in the summary plan description (SPD) and summary of benefits of coverage (SBC). Depending on the level of detail included in the SPD or SBC, this may mean making necessary updates and required notifications when covered items/services change.

EPIC Employee Benefits Compliance Services

For further information on this or any other topics, please contact your EPIC benefits consulting team.