The ACA Is Alive and Well: Updates to Mandated Preventive Health Care Services Issued for 2018

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The Patient Protection and Affordable Care Act of 2010 (ACA) revolutionized the U.S. healthcare system. Among the many major changes the ACA introduced was mandatory coverage of preventive care services required for most private health plans. Although most plan sponsors are well-aware of the ACA’s requirements for first dollar coverage on preventive care benefits, it may come as a surprise that the list of preventive care services is subject to annual updates, and there are several new requirements for 2018 and 2019. Generally, section 2713 of the ACA requires private health plans to provide coverage for a range of preventive care services without cost-sharing requirements (such as copayments, deductibles, or coinsurance requirements) for patients. For these purposes, a “private health plan” is (i) an insured individual, small group, or large group plan; or (ii) a self-insured plan that contracts with a third-party payor to provide administrative services. Certain “grandfathered” private health plans are exempt from this requirement. The mandated coverage generally became effective in 2011; mandates for clinical preventive services were effective for plan years starting after August 1, 2012.

There are several mandatory preventive care benefits required under the ACA:

1. Evidence-based screenings and counseling;
2. Routine immunizations;
3. Preventive services for children and youth; and
4. Preventive services for women.

There are a number of individual preventive care services within each of these broad groups for which the ACA mandates coverage based on the formal recommendations of the following agencies:

1. The U.S. Preventive Services Task Force (USPSTF);
2. The Advisory Committee on Immunization Practices (ACIP);
3. Bright Futures/American Academy of Pediatrics (Bright Futures);
4. The Advisory Committee on Heritable Disorders in Newborns and Children; and
5. The Health Resources and Services Administration (HRSA).

These agencies periodically issue updates to their lists of recommended preventive services. As a result, the list of services that plans must cover without cost sharing changes on an annual basis. The ACA requires non-grandfathered health plans to
provide first dollar coverage for the recommended preventive care service as of the first day of the plan or policy year one year after the recommended update is issued. Note that the rules vary as to when a particular guideline is considered “issued.” For example, recommendations of the USPSTF are considered issued on the last day of the month in which they are published or released; however, guidelines of the ACIP are not considered issued until adopted by the Director of the Centers for Disease Control and Prevention (CDC). Similarly, guidelines of the HRSA are not issued until accepted by the Administrator of the HRSA or adopted by the Secretary of the Department of Health and Human Services. This can create some confusion in determining when a plan must cover the recommendation without cost sharing under the ACA, as opposed to when the particular preventive care service is recommended for patients.

The more significant changes to the mandated preventive care services for plan years beginning on or after January 1, 2011, follow below. (This list is not intended to be exhaustive. A complete listing of all of the mandated preventive care services currently in effect under each of the four broad benefit categories would fill many pages and is beyond the scope of this article.)

**2018 and 2019 Plan Year Updated Mandated Preventive Health Care Services**

1. **Aspirin.** Aspirin preventive medication for adults aged 50 to 59 years having a more than 10 percent 10-year cardiovascular risk (mandated as of the first day of the plan year on or after January 1, 2018).

2. **Statin.** Statin preventive medication for adults aged 40 to 75 years with no history of cardiovascular disease (CVD), one or more cardiovascular disease risk factors, and a calculated 10-year CVD event risk of 10 percent or greater (mandated as of the first day of the plan year on or after January 1, 2018).

3. **Folic Acid.** Daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid for all women planning to become pregnant or who are capable of pregnancy (mandated as of the first day of the plan year on or after January 1, 2019).

4. **Hearing Loss.** Screening for hearing loss in newborn infants is no longer required.

5. **Obesity.** Screening for obesity in children and adolescents, six years and older, together with offering or referring them to comprehensive, intensive behavioral interventions to help promote improvements in weight status (mandated as of the first day of the plan year on or after January 1, 2019).

6. **Preeclampsia.** Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy (mandated as of the first day of the plan year on or after January 1, 2019).

7. **Vision.** Vision screening at least once in all children ages three to five years to detect amblyopia or its risk factors (mandated as of the first day of the plan year on or after January 1, 2019).

8. **Immunization.** A revised immunization schedule for children and adolescents, age 18 or younger, includes changes with respect to the following (mandated as of the first day of the plan year on or after January 1, 2018):
   - Haemophilus vaccine
   - HPV vaccine
   - Meningococcal B vaccine
   - Revised schedule makes other clarifying changes.
A revised immunization schedule for children and adolescents age 18 or younger, including revised rules for the following vaccines (mandated as of the first day of the plan year on or after January 1, 2019):

- Hepatitis B vaccine
- Poliomyelitis vaccine
- Diphtheria and tetanus toxoids and acellular pertussis
- Haemophilus influenzae type B vaccine
- Human papillomavirus vaccine
- Influenza vaccine
- Meningococcal vaccine
- Pneumococcal

Extensive changes made since 2016 to the Bright Futures Project recommendations (mandated as of the first day of the plan year on or after January 1, 2019), including:

- Updates to the timing and follow-up for a number of existing recommendations
- New bilirubin screening requirements for newborns
- New screening requirements for maternal depression
- Other changes as set forth in official detailed schedules

Revised nominated conditions to the Recommended Uniform Screening Panel (RUSP) as of February 2016 (mandated as of first day of plan year on or after January 1, 2018), including:

- Adrenoleukodystrophy (ALD)
- MPSI (alpha-L-iduronidase deficiency)

A major overhaul of preventive service requirements for women, including the following (mandated as of the first day of the plan year on or after January 1, 2018):

- Breast cancer screening for average-risk women. Mammography exams are to be performed at least biennially beginning at age 40, continuing through age 74 (but age is not a basis to discontinue screening).
- Women at an increased risk for breast cancer should undergo mammography “periodically.”
- Imaging tests, biopsies, or other interventions are required to be considered an integral part of “screening.”

- Cervical cancer screening for average-risk women. Women between the ages of 21 and 29 should be screened for cervical cancer using a PAP test every three years. Women between the ages of 30 and 65 should be screened with cytology and human papillomavirus testing every 5 years or with cytology alone every 3 years. Women with an average risk should not be screened more than once every three years.

- Contraception. Adolescent and adult women must have access to the full range of female-controlled contraceptives to prevent unintended pregnancies and
improve birth outcomes; counseling and follow-up care are included in this requirement.

1. **Screening for gestational diabetes mellitus.** Pregnant women should be screened after 24 weeks of gestation; women with risk factors for diabetes should be screened prior to 24 weeks of gestation.

2. **Screening for human immunodeficiency virus (HIV) infection.** Coverage for preventive education and risk assessment in adolescents and all women, based on risk, is mandated; education and assessment occurs annually based on risk, but may be more frequent for increased-risk cases.

3. **Screening for interpersonal and domestic violence.** Annual screening for adolescents and women is required and, when needed, the provision of or referral to initial intervention services, which include counseling, education, harm reduction strategies, and referral to appropriate supportive services.

4. **Counseling for sexually transmitted diseases.** Annual, directed behavioral counseling by a health care provider or other trained provider for sexually active adolescent and adult women at increased risk.

5. **Well-woman preventive visits.** Preventive care visits to ensure that recommended preventive services (including preconception) are made on an annual basis, although several visits may be required, depending on health status and needs

### Implications

The newly required, mandated preventive health care benefits for 2018 and 2019 will require private insurers and administrators of self-funded health plans to ensure that their coverage requirements encompass each of the newly added items, as applicable. Additionally, plan documents, benefits schedules, summary plan descriptions (SPDs) and similar communications, and any related materials should be carefully reviewed and updated, where appropriate. Wherever possible, plan administrators should provide advance notice to all participants and beneficiaries of the major changes well prior to the effective date of the changes (for example, during open enrollment). A number of the changes are highly technical and would not necessarily require references in SPDs and/or open enrollment materials.

We will also continue to keep you apprised of the compliance requirements of the ACA and related laws as further developments arise.