



# **New Preventive Services FAQs Issued May 11, 2015**



***Center for Consumer  
Information and  
Insurance Oversight***

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# What Must Be Covered Under ACA?

- Under ACA, non-grandfathered individual and group (employment-based) plans and insurers must cover certain recommended preventive services, without cost-sharing.
- Currently includes 18 methods of women's contraception identified by the FDA in its current Birth Control Guide

# Confusion

- Confusion about the extent to which plans and insurers can deny coverage, or impose cost sharing, for any of the current 18 methods, or for specific items and services within each of the 18 methods.
- For example, IUDs with progestin. Must plan cover every FDA-approved one on the market, with no cost sharing?

# Three Departments Issue Clarifying FAQs on May 11, 2015

- Plans and insurers must cover, without cost sharing, at least one form of contraception in each of the 18 methods.
- Can use reasonable medical management, such as charging cost sharing, to “steer” women to a particular form within a method (e.g., one particular IUD with progestin).
- HOWEVER...

# Medical Necessity

- If enrollee's attending provider recommends a particular service or FDA-approved item based on medical necessity for that enrollee, plan/issuer must cover it for that enrollee, without cost sharing.
- This exceptions process must be easily accessible, transparent, and sufficiently expedient, and not unduly burdensome on the patient or provider.
- The plan or issuer must defer to the determination of the attending provider.

# BRCA 1 or BRCA 2

- As part of preventive services coverage, plans/insurers must cover, without cost sharing, screenings for enrollees who have family members with breast, ovarian, tubal, or peritoneal cancer, to identify a family history that may be associated with increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2).

# New FAQ on BRCA 1 and BRCA 2

- New FAQ clarifies that plans/insurers must cover, without cost sharing, counseling and BRCA testing for women who previously had breast, ovarian, or other cancer, as long as the woman has not been diagnosed with BRCA-related cancer and found to be at significant increased risk through screening.

# Gender-Based Preventive Services

- New FAQ clarifies that plans/insurers may not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, their gender identity, or their recorded gender.
- Whether a sex-specific recommended preventive service is medically appropriate for a specific individual is determined by individual's attending provider.



# Gender-Based Preventive Services (cont'd)

- **EXAMPLE:** When an attending provider determines that a mammogram or a pap smear for a transgender man who has residual breast tissue or an intact cervix is appropriate, plan or insurer must cover the service, with no cost sharing, as long as other criteria are met.

# FAQ on Preventive Services for Dependent Children

- ACA does not require plans or insurers to cover dependent children (but must cover them up to age 26 if they do).
- New FAQ clarifies that if plan or insurer DOES cover dependent children, it must cover all recommended preventive services for them, with no cost sharing, including those related to pregnancy, such as preconception and prenatal care.

# FAQ on Anesthesia Services Associated with Colonoscopy

- ACA requires coverage for preventive screening colonoscopies in certain circumstances, with no cost sharing. Can plan or insurer impose cost sharing on associated anesthesia services?
- FAQ: No (as long as attending provider determines that anesthesia is medically appropriate for the individual).

# URL for New Preventive Service FAQs

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- [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca\\_implementation\\_faqs26.pdf](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf)