Subject: **Coverage for Preventive Services**
Date: May 20, 2015

On May 11, 2015, the Departments of Health and Human Services, Labor and Treasury released another set of FAQs relating to coverage of preventive services. As background, the Affordable Care Act (ACA) requires non-grandfathered plans in the individual and group markets to provide specified preventive services at no cost to plan participants.

- **Contraceptive coverage.** Of particular note, the FAQ clarifies the requirement to cover contraceptive services, probably in large part in response to plans interpreting this requirement more narrowly than the law intends. This guidance affirms that individual and group health plans, whether insured or self-funded, must cover at least one form of contraception in each of the methods, as approved by the Food and Drug Administration (FDA). These FDA-approved methods* are:

Surgical Sterilization Implant for Women	Patch
Implantable Rod	Vaginal Contraceptive Ring
IUD Copper	Diaphragm with Spermicide
IUD w/ Progestin	Sponge with Spermicide
Injection	Cervical Cap with Spermicide
Oral Contraceptives(Combined Pill) “The Pill”	Female Condom
Oral Contraceptives (Progestin only) “The MiniPill”	Spermicide
Oral Contraceptives Extended/Continuous Use “The Pill”	Emergency contraception

**While the FDA-approved methods additionally list sterilization surgery for men and male condoms, the ACA does not require these services to be covered.*

The guidance further clarifies that contraceptive coverage must also include clinical services, including patient education and counseling, needed for the particular contraceptive method.

Within each method, a plan may utilize reasonable medical management techniques. If it does, it must defer to the recommendations of a health care provider. Further, the plan must have an exception process that is readily available and prompt.

According to this guidance, the government recognizes that plans may not have understood the need to comply in this manner. Therefore, enforcement will begin to apply in the first plan or policy year occurring 60 days following publication of the FAQ (July 10, 2015).

- **Breast cancer screening.** One of the recommended guidelines for appropriate cancer screenings relates to testing for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2). The guidance clarifies that coverage for such screenings, together with genetic counseling, must be provided even in asymptomatic women when recommended by their attending physician.

- **Well-woman Preventive Care for Dependents**. The guidance clarifies that plans covering dependents must also cover recommended well-woman preventive services for dependent children when determined to be age and developmentally-appropriate for the dependent by the attending provider.

- **Colonoscopy coverage**. Plans cannot impose cost sharing relating to anesthesia services used in connection with a colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the individual.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.