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 first 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. 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:

- evidence-based screenings and counseling;
- routine immunizations;
- preventive services for children and youth; and
- 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:

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

The lists of covered services that these agencies recommend are updated, and coverage without cost sharing is mandated as of the first day of the plan or policy year one year after the recommended update. Mid-year changes in covered services are usually not required unless an agency finds that a mandated service is harmful or poses a significant safety risk.

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 Plan Year Updated Mandated Preventive Health Care Services**

Coverage is required for a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid for all women planning to becoming pregnant, or who are capable of pregnancy.

Screening for hearing loss in newborn infants is no longer required.

Screening for obesity in children and adolescents, six years of age and older, is mandated together with offering or referring them to comprehensive, intensive behavioral interventions to help promote improvements in weight status.

Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy is mandated.

A revised immunization schedule for children and adolescents, age 18 or younger, includes the following changes:

- Revised rules for hepatitis B, poliomyelitis, human papillomavirus, influenza, and meningococcal vaccines
- Addition of a new schedule for vaccines provided based on certain medical conditions
- Revised requirements for diphtheria and tetanus toxoids, and acellular pertussis, hemophilia, influenza type B, and pneumococcal vaccines

An extensive summary of changes made to the Bright Futures Project recommendations, include the following:

- Updates to establish 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

A major overhaul of mandated preventive service requirements for 2018, includes the following:

• **Breast cancer screening for average-risk women**—Mammography exams are to be performed at least biennially beginning at age 40, continuing through age 50, and ending at age 74 (but age is no basis to discontinue screening).
  
  ◦ Women at 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 30 and 65 should be screened with cytology and human papillomavirus testing every 5 years, or with cytology alone every 3 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.

• **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.

• **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.

• **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 appropriate supportive services.

• **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 is mandated.

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

The newly required, mandated preventive health care benefits for 2018 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.


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