**Template Bulletin from State Commissioner of Insurance to Insurers**

TO: ALL INSURERS

FROM: [NAME], COMMISSIONER OF INSURANCE (or applicable title)

DATE: XXX

RE: COMPANY BULLETIN CB 2021 - \_\_ (or applicable format)

PREVENTIVE SERVICES REQUIRED BY AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (ACA) expands requirements for coverage of clinical preventive services under Medicare, Medicaid and in the private insurance market. The purpose of this Bulletin is to alert all insurance companies doing business in [STATE] of the preventive service requirements and request each issuer to inform the Department of Insurance of their coverage of evidence-based clinical preventive services.

Prior to the ACA, federal law did not require group health plans and health issuers to cover preventive services. Within six months of enactment of the ACA (September 23, 2010), group health plans and health insurance issuers in the group and individual markets were required to cover specified evidence-based clinical preventive services, without any cost sharing. This includes coverage of preventive care under four broad categories: evidence-based screenings and counseling, routine immunization, childhood preventive services, and preventive services for women. Health plans in existence when the ACA was enacted are “grandfathered” under the law and are exempt from this requirement.

The ACA requires plans to cover any evidence-based items or services that have an ‘A’ or ‘B’ rating in the current recommendations of the United State Preventive Services Task Force (USPSTF). For example, as of April 30, 2009, and most recently updated on January 19, 2021, the USPSTF recommends with an ‘A’ rating that, clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. The USPSTF indicates that, “combination therapy with counseling and medications is more effective than either [counseling or pharmacotherapy] alone.”

In May 2014, the Departments of Labor, Health and Human Services and Treasury issued guidance on this tobacco cessation requirement, stating that:

“a group health plan or health insurance issuer [would] be in compliance with the requirement to cover tobacco use counseling and interventions, if, for example, the plan or issuer covers without cost-sharing: Screening for tobacco use; and, For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for: Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.”

This guidance can be found in [Affordable Care Act implementation FAQ XIX](https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xix.pdf), Question 5. Additional guidance on other preventive service requirements can also be found in this [series of FAQ’s on the Department of Labor’s website](https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs).

Insurers should inform the Department of their coverage of evidence based clinical services with a USPTF rating of A or B, as well as utilization management and cost-sharing provisions, if any, for plans submitted for the new plan year. Utilization management provisions might include: annual or lifetime limits on benefits, prior authorization requirements and stepped care therapy requirements. Cost-sharing provisions might include co-payments, co-insurance or deductible requirements.