Congressional Research Service
Informing the legislative debate since 1914

IN FOCUS

May 23, 2025

The ACA Preventive Services Coverage Requirement

Per the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), most private health insurance plans are required to cover specified preventive services and items without consumer cost sharing. This includes coverage of dozens of preventive services and items—such as screenings, counseling, vaccines, and preventive medications—for millions of women, men, and children.

This In Focus provides an overview of the preventive services coverage requirement. It includes enrollee estimates and outlines considerations for potential legislative changes. It also provides context relevant to the *Kennedy v. Braidwood* challenge to this coverage requirement, currently before the Supreme Court. A CRS Legal Sidebar provides more information on the *Braidwood* case.

Overview

Section 1001 of ACA, adding Section 2713 of the Public Health Service Act (PHSA), requires private health insurance coverage without cost sharing of specified preventive services and items. Per statute and regulations, this includes at least the preventive services and items in the following four categories:

- Evidence-based items or services recommended with an "A" or "B" rating by the United States Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP), adopted by the Centers for Disease Control and Prevention (CDC), for routine use for a given individual;
- Evidence-informed preventive care and screenings for infants, children, and adolescents as provided in guidelines supported by the Health Resources and Services Administration (HRSA); and
- Additional preventive care and screenings for women as provided in guidelines supported by HRSA.

Four Preventive Services Categories

Following are examples of recommendations and guidelines in each of the four categories above. Additional details are available on the relevant websites (e.g., USPSTF). The complete list of preventive services and items required to be covered, per all categories, is available at HealthCare.gov.

USPSTF "A" and "B" Recommendations

The USPSTF is an independent, volunteer panel of experts that issues evidence-based recommendations on the provision of clinical preventive services for patients across the lifespan. The USPSTF generally assigns grades (A, B, C, D, and I) to recommend or discourage a preventive service, or to indicate uncertain evidence. Relevant to the preventive services coverage requirement, there are currently about 50 USPSTF recommendations with A and B grades, many of which are related to

- Cancer screenings and preventive care;
- Mental health and substance use screenings and referrals;
- Cardiovascular disease (CVD), healthy weight, and diabetes prevention screenings and care;
- Sexually transmitted infection (STI) and other infectious disease preventive screenings and care; and
- Preventive care for prenatal and postpartum individuals, for newborns and children, and for older adults.

Most recommendations are population-based (e.g., based on age and/or sex) and may specify frequency or other details. For example, cervical cancer screenings are recommended every three years for women aged 21-29 and every three to five years for women aged 30-65, using specified methods.

Many of the recommendations are for preventive *services*, such as diabetes screenings for certain adults and primary care education or counseling to prevent tobacco use among school-age children and adolescents. There are also recommendations for preventive *medications* such as statins for adults at increased risk of CVD and preexposure prophylaxis (PrEP) therapy for adolescents and adults at increased risk of human immunodeficiency virus (HIV).

ACIP Recommended Vaccines

The ACIP is a federal advisory committee that makes recommendations on pediatric and adult vaccines. For purpose of the preventive services coverage requirement, ACIP recommendations are considered adopted by the CDC for routine use if they are listed on the CDC immunization schedules. These schedules currently include

- Pediatric vaccines through the age of 18, including to protect against diphtheria, tetanus, and pertussis; measles, mumps, and rubella; influenza; COVID-19; and human papillomavirus (HPV); and
- Adult vaccines for individuals aged 19 and older, including to protect against respiratory syncytial virus (RSV), shingles, mpox, influenza, and COVID-19.

The immunization schedules include recommendations by age and for other population or risk-based groups (e.g., by sex or health condition) and include any precautions or contraindications.

Coverage of COVID-19 vaccines, as recommended by ACIP, also is required per Section 3203 of the Coronavirus

Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136), added as a note to PHSA Section 2713.

HRSA/Bright Futures Pediatric Guidelines

HRSA has a cooperative agreement with the American Academy of Pediatrics to provide guidelines on pediatric preventive services. HRSA determines whether to adopt their guidelines, which are updated via the "Bright Futures" Periodicity Schedule. Current guidelines include

- Physical screenings and procedures by age (e.g., height and weight measurements, lead and anemia screenings, vision and hearing screenings, and STI screenings for adolescents) and
- Developmental screenings by age (e.g., for autism spectrum disorder, behavioral/social/emotional concerns, and depression and suicide risk).

HRSA/WPSI Guidelines for Women

HRSA also has a cooperative agreement with the American College of Obstetricians & Gynecologists (ACOG) to provide guidelines on women's preventive services. ACOG has convened the Women's Preventive Services Initiative (WPSI) for this purpose. HRSA determines whether to adopt WPSI's recommendations as the HRSA Women's Preventive Services Guidelines. Current guidelines include

- Contraceptives and contraceptive care, as specified;
- Breast and cervical cancer screenings, diabetes and obesity prevention, breastfeeding support, and other preventive services (some topics are addressed by both HRSA/WPSI and USPSTF); and
- Well-woman visits for the delivery of HRSA/WPSI, USPSTF, and ACIP-recommended services and items.

Coverage and Cost-Sharing Details

Regulations and guidance have provided additional details on the preventive services coverage requirement. Overall, applicable plans must provide coverage of recommended services and items, as specified (e.g., for individuals of a certain age and/or sex, at recommended intervals) without consumer cost sharing, including deductibles, co-payments, or coinsurance.

Plans may determine coverage limitations by relying on "reasonable medical management" techniques, to the extent that a recommendation or guideline does not specify the frequency, method, treatment, or setting for the service. For example, plans may limit coverage and require cost sharing on pediatric screenings and vaccines beyond what is recommended for a given child (e.g., based on age).

Plans also must cover, without cost sharing, items and services that are "integral to the furnishing of a recommended preventive service," such as polyp removal and biopsy related to a preventive screening colonoscopy. However, cost sharing for office visits associated with recommended preventive services may or may not be allowed, as specified in regulations.

Preventive services provided out of network are generally not required to be covered without cost sharing, unless no in-network provider is available to deliver the service.

If there are changes in recommendations or guidelines in any category, plans generally must provide coverage as of plan years that begin one year after the change. For example, a new HRSA/WPSI guideline on patient navigation services for breast and cervical cancer screening was published in December 2024. Plans beginning on or after January 1, 2026, must include such coverage.

If a service is provided for a purpose other than prevention (e.g., a mammogram to *diagnose* symptoms, rather than a *screening* mammogram as recommended), it is generally not required to be covered per PHSA Section 2713. Plans otherwise may cover such services, with or without cost sharing, voluntarily or subject to other federal or state requirements, if any.

Applicable Plans and Enrollee Estimates

Most private health insurance plans are subject to the preventive services coverage requirement. This includes large-group, small-group, self-insured, and nongroup plans (i.e., different types of employment-based plans, and plans sold on and off the health insurance exchanges). The requirement does not apply to certain types of plans, such as grandfathered plans. In addition, plans may be exempt from contraceptive coverage due to religious or moral objections.

Between 150 million and 180 million individuals are enrolled in a plan subject to the preventive services coverage requirement, per agency report, rulemaking, and stakeholder estimates on 2020 and 2023 coverage. Another analysis found that in 2018, about 60% of private health insurance enrollees (roughly 100 million people) received preventive care subject to the coverage requirement.

Considerations for Congress

Aside from legal considerations related to the *Braidwood* case currently before the Supreme Court, Congress may consider changing the existing coverage requirement, either through amendments to PHSA Section 2713 or through new legislation. For example, Congress may seek to

- Revise the coverage requirement (e.g., by eliminating categories of coverage, requiring coverage beyond what is currently recommended, or basing coverage requirements on something other than the categories of recommendations);
- Address related coverage and cost-sharing details, including by codifying or changing the requirements currently in regulations and guidance; and/or
- Increase or decrease the applicability of the coverage requirement to different types of plans.

Any policy changes may affect access to and utilization of preventive care, which may affect health outcomes. There also could be cost implications for insurers, employers, and consumers, as well as the federal government (e.g., in terms of premium subsidies). However, the utilization, cost, and other effects of any policy changes also would depend on factors such as variations in existing coverage (including per state requirements), consumer access to health care providers, amounts paid to providers, changes in use of other health care services, and population health dynamics.

Vanessa C. Forsberg, Analyst in Health Care Financing

IF13010

Disclaimer