(b) The additive is used or intended for use as a feed acidifying agent, to lower the pH, in complete swine feeds at levels not to exceed 1.2 percent of the complete feed.

(c) To assure safe use of the additive, in addition to the other information required by the Federal Food, Drug, and Cosmetic Act (the act), the label and labeling shall contain:

1. The name of the additive.
2. Adequate directions for use including a statement that ammonium formate must be uniformly applied and thoroughly mixed into complete swine feeds and that the complete swine feeds so treated shall be labeled as containing ammonium formate.
3. To assure safe use of the additive, in addition to the other information required by the act and paragraph (c) of this section, the label and labeling shall contain:

1. Appropriate warnings and safety precautions concerning ammonium formate (37 percent ammonium salt of formic acid and 62 percent formic acid).
2. Statements identifying ammonium formate in formic acid (37 percent ammonium salt of formic acid and 62 percent formic acid) as a corrosive and possible severe irritant.
3. Information about emergency aid in case of accidental exposure as follows:
   i. Statements reflecting requirements of applicable sections of the Superfund Amendments and Reauthorization Act (SARA), and the Occupational Safety and Health Administration’s (OSHA) human safety guidance regulations.
   ii. Contact address and telephone number for reporting adverse reactions or to request a copy of the Material Safety Data Sheet (MSDS).

Dated: July 14, 2010.

Tracey H. Forfa,
Acting Director, Center for Veterinary Medicine.

[FR Doc. 2010–17565 Filed 7–16–10; 8:45 am]
headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1–800–743–3951.

Internal Revenue Service. Comments to the IRS, identified by REG–120391–10, by one of the following methods: • Federal eRulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments. • Mail: CC:PA:LPD:PR (REG–120391–10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.

Hand or courier delivery: Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG–120391–10), Courier’s Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC 20224.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW., Washington, DC from 9 a.m. to 4 p.m.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Beth Baun, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622–6080; Jim Mayhew, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, at (410) 786–1565.

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the Department of Labor’s Web site (https://www.dol.gov/ebsa). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) Web site (http://www.cms.hhs.gov/HealthInsReformforConsumers/01_Overview.asp) and information on health reform can be found at http://www.healthcare.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act (the Affordable Care Act), Public Law 111–148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (the Reconciliation Act), Public Law 111–152, was enacted on March 30, 2010. The Affordable Care Act and the Reconciliation Act reorganize, amend, and add to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term “group health plan” includes both insured and self-insured group health plans.1 The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by this reference are sections 2701 through 2728. PHS Act sections 2701 through 2719A are substantially new, though they incorporate some provisions of prior law. PHS Act sections 2722 through 2728 are sections of prior law renumbered, with some, mostly minor, changes.

Subtitles A and C of title I of the Affordable Care Act amend the requirements of title XXVII of the PHS Act (changes to which are incorporated into ERISA section 715). The preemption provisions of ERISA section 731 and PHS Act section 2724 2 (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the requirements of part 7 of ERISA and title XXVII of the PHS Act, as amended by the Affordable Care Act, are not to be “construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement” of the Affordable Care Act. Accordingly, State laws that impose on health insurance issuers requirements that are stricter than those imposed by the Affordable Care Act will not be superseded by the Affordable Care Act.

1 The term “group health plan” is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term “health plan,” as used in other provisions of title I of the Affordable Care Act. The term “health plan” does not include self-insured group health plans.

2 Code section 9815 incorporates the preemption provisions of PHS Act section 2724. Prior to the Affordable Care Act, there were no express preemption provisions in chapter 100 of the Code.
The Departments of Health and Human Services, Labor, and the Treasury (the Departments) are issuing regulations in several phases implementing the revised PHS Act sections 2701 through 2719A and related provisions of the Affordable Care Act. The first phase in this series was the publication of a Request for Information relating to the medical loss ratio provisions of PHS Act section 2718, published in the Federal Register on April 14, 2010 (75 FR 19297). The second phase was interim final regulations implementing PHS Act section 2714 (requiring dependent coverage of children to age 26), published in the Federal Register on May 13, 2010 (75 FR 27122). The third phase was interim final regulations implementing section 1251 of the Affordable Care Act (relating to status as a grandfathered health plan), published in the Federal Register on June 17, 2010 (75 FR 34538). The fourth phase was interim final regulations implementing PHS Act sections 2704 (prohibiting preexisting condition exclusions), 2711 (regarding lifetime and annual dollar limits on benefits), 2712 (regarding restrictions on rescissions), and 2719A (regarding patient protections), published in the Federal Register on June 28, 2010 (75 FR 37188). These interim final regulations are being published to implement PHS Act section 2713 (relating to coverage for preventive services). PHS Act section 2713 is generally effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010, which is six months after the March 23, 2010 date of enactment of the Affordable Care Act. The implementation of other provisions of PHS Act sections 2701 through 2719A will be addressed in future regulations.


Section 2713 of the PHS Act, as added by the Affordable Care Act, and these interim final regulations require that a group health plan and a health insurance issuer offering group or individual health insurance coverage provide benefits for and prohibit the imposition of cost-sharing requirements with respect to:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be “in effect” after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

The Department of HHS is developing recommendations of the Task Force (Task Force) with respect to the individual involved.

Under PHS Act section 2713(a)(5), the Task Force recommendations regarding breast cancer screening, mammography, and prevention issued in or around November of 2009 are not to be considered current recommendations on this subject for purposes of any law. Thus, the recommendations regarding breast cancer screening, mammography, and prevention issued by the Task Force prior to those issued in or around November of 2009 (i.e., those issued in 2002) will be considered current until new recommendations in this area are issued by the Task Force or appear in comprehensive guidelines supported by the Health Resources and Services Administration concerning preventive care and screenings for women.

With respect to a plan or health insurance coverage that has a network of providers, these interim final regulations make clear that a plan or issuer is not required to provide coverage for recommended preventive services delivered by an out-of-network provider. Such a plan or issuer may also impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider.

These interim final regulations provide that if a recommendation or...
guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques to determine any coverage limitations. The use of reasonable medical management techniques allows plans and issuers to adapt these recommendations and guidelines to coverage of specific items and services where cost sharing must be waived. Thus, under these interim final regulations, a plan or issuer may rely on established techniques and the relevant evidence base to determine the frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.

The statute and these interim final regulations clarify that a plan or issuer continues to have the option to cover preventive services in addition to those required to be covered by PHS Act section 2715(d)(4). For such additional preventive services, a plan or issuer may impose cost-sharing requirements at its discretion. Moreover, a plan or issuer may impose cost-sharing requirements for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

The statute requires the Departments to establish an interval of not less than one year between when recommendations or guidelines under PHS Act section 2713(a) are issued, and the plan year (in the individual market, policy year) for which coverage of the services addressed in such recommendations or guidelines must be in effect. These interim final regulations provide that such coverage must be provided for plan years (in the individual market, policy years) beginning on or after the later of September 23, 2010, or one year after the date the recommendation or guideline is issued. Thus, recommendations and guidelines issued prior to September 23, 2009 must be provided for plan years (in the individual market, policy years) beginning on or after September 23, 2010. For the purpose of these interim final regulations, a recommendation or guideline of the Task Force is considered to be issued on the last day of the month on which the Task Force publishes or otherwise releases the recommendation; a recommendation or guideline of the Advisory Committee is considered to be issued on the date on which it is adopted by the Director of the Centers for Disease Control and Prevention; and a recommendation or guideline in the comprehensive guidelines supported by HRSA is considered to be issued on the date on which it is accepted by the Administrator of HRSA or, if applicable, adopted by the Secretary of HHS. For recommendations and guidelines adopted after September 23, 2009, information at http://www.HealthCare.gov/center/regulations/prevention.html will be updated on an ongoing basis and will include the date on which the recommendation or guideline was accepted or adopted.

Finally, these interim final regulations make clear that a plan or issuer is not required to provide coverage or waive cost-sharing requirements for any item or service that has ceased to be a recommended preventive service.5 Other requirements of Federal or State law may apply in connection with ceasing to provide coverage or changing cost-sharing requirements for any such item or service. For example, PHS Act section 2715(d)(4) requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective. Recommendations or guidelines in effect as of July 13, 2010 are described in section V later in this preamble. Any change to a recommendation or guideline that has—at any point since September 23, 2009—been included in the recommended preventive services will be noted at http://www.HealthCare.gov/center/regulations/prevention.html. As described above, new recommendations and guidelines will also be noted at this site and plans and issuers need not make changes to coverage and cost-sharing requirements based on a new recommendation or guideline until the first plan year (in the individual market, policy year) beginning on or after the date that is one year after the new recommendation or guideline went into effect. Therefore, by visiting this site once per year, plans or issuers will have straightforward access to all the information necessary to determine any additional items or services that must be covered without cost-sharing requirements, or to determine any items or services that are no longer required to be covered.

The Affordable Care Act gives authority to the Departments to develop guidelines for group health plans and health insurance issuers offering group or individual health insurance coverage to utilize value-based insurance designs as part of their offering of preventive health services. Value-based insurance designs include the provision of information and incentives for consumers that promote access to and use of higher value providers, treatments, and services. The Departments recognize the important role that value-based insurance design can play in promoting the use of appropriate preventive services. These interim final regulations, for example, permit plans and issuers to implement designs that seek to foster better quality and efficiency by allowing cost-sharing for recommended preventive services delivered on an out-of-network basis while eliminating cost-sharing for recommended preventive health services delivered on an in-network basis. The Departments are developing additional guidelines regarding the utilization of value-based insurance designs by group health plans and health insurance issuers with respect to preventive benefits. The Departments are seeking comments related to the development of such guidelines for value-based insurance designs that promote consumer choice of providers or services that offer the best value and quality, while ensuring access to critical, evidence-based preventive services.

The requirements to cover recommended preventive services without any cost-sharing requirements do not apply to grandfathered health plans. See 26 CFR 54.9815–1251T, 29 CFR 2590.715–1251, and 45 CFR 147.140 (75 FR 34538, June 17, 2010).

III. Interim Final Regulations and Request for Comments

Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS

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4 Section 2713(b)(1) refers to an interval between “the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.” While the first part of this statement does not mention guidelines under subsection (a)(4), it would make no sense to treat the services covered under subsection (a)(4) any differently than those in subsection (a)(1), (a)(2), and (a)(3). First, the same sentence refers to “the requirement described in subsection (a)” which would include a requirement under subsection (a)(4). Secondly, the guidelines under subsection (a)(4) are from the same source as those under subsection (a)(3), except with respect to women rather than infants, children and adolescents; and other preventive services involving women are addressed in subsection (a)(1), so there is no plausible policy rationale for treating them differently. Third, without this clarification, it would be unclear when such services would have to be covered. These interim final regulations accordingly apply the intervals established therein to services under section 2713(a)(4).

5 For example, if a recommendation of the United States Preventive Services Task Force is downgraded from a rating of A or B to a rating of C or D, or if a recommendation or guideline no longer includes a particular item or service.
Act authorize the Secretaries of the Treasury, Labor, and HHS (collectively, the Secretaries) to promulgate any interim final rules that they determine are appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B of title I of ERISA, and part A of title XXVII of the PHS Act, which include PHS Act sections 2701 through 2728 and the incorporation of those sections into ERISA section 715 and Code section 9815.

In addition, under Section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 551 et seq.), a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. The provisions of the APA that ordinarily require a notice of proposed rulemaking do not apply here because of the specific authority granted by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act. However, even if the APA were applicable, the Secretaries have determined that it would be impracticable and contrary to the public interest to delay putting the provisions in these interim final regulations in place until a full public notice and comment process was completed. As noted above, the preventive health service provisions of the Affordable Care Act are applicable for plan years (in the individual market, policy years) beginning on or after September 23, 2010, six months after date of enactment. Had the Departments published a notice of proposed rulemaking, provided for a 60-day comment period, and only then prepared final regulations, which would be subject to a 60-day delay in effective date, it is unlikely that it would have been possible to have final regulations in effect before late September, when these requirements could be in effect for some plans or policies. Moreover, the requirements in these interim final regulations require significant lead time in order to implement. These interim final regulations require plans and issuers to provide coverage for preventive services listed in certain recommendations and guidelines without imposing any cost-sharing requirements. Preparations presumably would have to be made to identify these preventive services. With respect to the changes that would be required to be made under these interim final regulations, group health plans and health insurance issuers subject to these provisions have to be able to take these changes into account in establishing their premiums, and in making other changes to the designs of plan or policy benefits, and these premiums and plan or policy changes would have to receive necessary approvals in advance of the plan or policy year in question.

Accordingly, in order to allow plans and health insurance coverage to be designed and implemented on a timely basis, regulations must be published and available to the public well in advance of the effective date of the requirements of the Affordable Care Act. It is not possible to have a full notice and comment process and to publish final regulations in the brief time between enactment of the Affordable Care Act and the date regulations are needed.

The Secretaries further find that issuance of proposed regulations would not be sufficient because the provisions of the Affordable Care Act protect significant rights of plan participants and beneficiaries and individuals covered by individual health insurance policies and it is essential that participants, beneficiaries, issuers, plan sponsors, and issuers have certainty about their rights and responsibilities. Proposed regulations are not binding and cannot provide the necessary certainty. By contrast, the interim final regulations provide the public with an opportunity for comment, but without delaying the effective date of the regulations.

For the foregoing reasons, the Departments have determined that it is impracticable and contrary to the public interest to engage in full notice and comment rulemaking before putting these interim final regulations into effect, and that it is in the public interest to promulgate interim final regulations.

IV. Economic Impact

Under Executive Order 12866 (58 FR 51735), a “significant” regulatory action is subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order defines a “significant regulatory action” as an action that is likely to result in a rule (1) having an annual effect on the economy of $100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as “economically significant”; (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order. OMB has determined that this regulation is economically significant within the meaning of section 3(f)(1) of the Executive Order, because it is likely to have an annual effect on the economy of $100 million in any one year. Accordingly, OMB has reviewed these rules pursuant to the Executive Order. The Departments provide an assessment of the potential costs, benefits, and transfers associated with these interim final regulations, summarized in the following table.

<table>
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<th>TABLE 1—ACCOUNTING TABLE (2011–2013)</th>
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Benefits:
Qualitative: By expanding coverage and eliminating cost sharing for the recommended preventive services, the Departments expect access and utilization of these services to increase. To the extent that individuals increase their use of these services the Departments anticipate several benefits: (1) prevention and reduction in transmission of illnesses as a result of immunization and screening of transmissible diseases; (2) delayed onset, earlier treatment, and reduction in morbidity and mortality as a result of early detection, screening, and counseling; (3) increased productivity and fewer sick days; and (4) savings from lower health care costs. Another benefit of these interim final regulations will be to distribute the cost of preventive services more equitably across the broad insured population.

Costs:
Qualitative: New costs to the health care system result when beneficiaries increase their use of preventive services in response to the changes in coverage and cost-sharing requirements of preventive services. The magnitude of this effect on utilization depends on the price elasticity of demand and the percentage change in prices facing those with reduced cost sharing or newly gaining coverage.

Transfers:
A. The Need for Federal Regulatory Action

As discussed later in this preamble, there is current underutilization of preventive services, which stems from three main factors. First, due to turnover in the health insurance market, health insurance issuers do not currently have incentives to cover preventive services, whose benefits may only be realized in the future when an individual may no longer be enrolled. Second, many preventive services generate benefits that do not accrue immediately to the individual that receives the service, making the individual less likely to take-up, especially in the face of direct, immediate costs. Third, some of the benefits of preventive services accrue to society as a whole, and thus do not get factored into an individual’s decision-making over whether to obtain such services.

These interim final regulations address these market failures through two avenues. First, they require coverage of recommended preventive services by non-grandfathered group health plans and health insurance issuers in the group and individual markets, thereby overcoming plans’ lack of incentive to invest in these services. Second, they eliminate cost-sharing requirements, thereby removing a barrier that could otherwise lead an individual to not obtain such services, given the long-term and partially external nature of benefits.

These interim final regulations are necessary in order to provide rules that plan sponsors and issuers can use to determine how to provide coverage for certain preventive health services without the imposition of cost sharing in connection with these services.


1. Summary

As discussed earlier in this preamble, PHS Act section 2713, as added by the Affordable Care Act, and these interim final regulations require a group health plan and a health insurance issuer offering group or individual health insurance coverage to provide benefits for and prohibit the imposition of cost-sharing requirements with respect to the following preventive health services:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force).
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved.
- Preventive counseling related to aspirin use, tobacco cessation, obesity, and other topics.
- Blood pressure and cholesterol screening, diabetes screening for hypertensive patients, various cancer and sexually transmitted infection screenings, and counseling related to aspirin use, tobacco cessation, obesity, and other topics.
- Screening for hypertensive patients, various cancer and sexually transmitted infection screenings, and counseling related to aspirin use, tobacco cessation, obesity, and other topics.
- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force).
- Blood pressure and cholesterol screening, diabetes screening for hypertensive patients, various cancer and sexually transmitted infection screenings, and counseling related to aspirin use, tobacco cessation, obesity, and other topics.
- Screening for hypertensive patients, various cancer and sexually transmitted infection screenings, and counseling related to aspirin use, tobacco cessation, obesity, and other topics.
- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force).
- Blood pressure and cholesterol screening, diabetes screening for hypertensive patients, various cancer and sexually transmitted infection screenings, and counseling related to aspirin use, tobacco cessation, obesity, and other topics.

2. Preventive Services

For the purposes of this analysis, the Departments used the relevant recommendations of the Task Force and Advisory Committee and current HRSA guidelines as described in section V later in this preamble. In addition to covering immunizations, these lists include such services as blood pressure and cholesterol screening, diabetes screening for hypertensive patients, various cancer and sexually transmitted infection screenings, genetic testing for the BRCA gene, adolescent depression screening, lead testing, autism testing, and oral health screening and counseling related to aspirin use, tobacco cessation, and obesity.

3. Estimated Number of Affected Entities

For purposes of the new requirements in the Affordable Care Act that apply to group health plans and health insurance issuers in the group and individual markets, the Departments have defined a large group health plan as an employer plan with 100 or more workers and a small group plan as an employer plan with less than 100 workers. The Departments estimated that there are approximately 72,000 large and 2.8 million small ERISA-covered group health plans with an estimated 97.0 million participants in large group plans and 40.9 million participants in small group plans. The Departments estimate that there are 126,000 governmental plans with 36.1 million participants in large plans and 2.3 million participants in small plans. The Departments estimate there are 16.7 million individuals under age 65 covered by individual health insurance policies.

As described in the Departments’ interim final regulations relating to status as a grandfathered health plan, the Affordable Care Act preserves the ability of individuals to retain coverage under a group health plan or health insurance coverage in which the individual was enrolled on March 23, 2010 (a grandfathered health plan). Group health plans, and group and individual health insurance coverage, that are grandfathered health plans do not have to meet the requirements of these interim final regulations. Therefore, only plans and issuers offering group and individual health insurance coverage that are not grandfathered health plans will be affected by these interim final regulations.

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6 All participant counts and the estimates of individual policies are from the U.S. Department of Labor, EBSA calculations using the March 2008 Current Population Survey Annual Social and Economic Supplement and the 2008 Medical Expenditure Panel Survey.
7 Estimate is from the 2007 Census of Government.
9 75 FR 34538 (June 17, 2010).
Plans can choose to relinquish their grandfather status in order to make certain otherwise permissible changes to their plans. The Affordable Care Act provides plans with the ability to maintain grandfathered status in order to promote stability for consumers while allowing plans and sponsors to make reasonable adjustments to lower costs and encourage the efficient use of services. Based on an analysis of the changes plans have made over the past few years, the Departments expect that more plans will choose to make these changes over time and therefore the number of grandfathered health plans is expected to decrease. Correspondingly, the number of plans and policies affected by these interim final regulations is likely to increase over time. In addition, the number of individuals receiving the benefits of the Affordable Care Act is likely to increase over time. The Departments’ mid-range estimate is that 18 percent of large employer plans and 30 percent of small employer plans would relinquish grandfathered status in 2011, increasing over time to 45 percent and 66 percent respectively by 2013, although there is substantial uncertainty surrounding these estimates.

Using the mid-range assumptions, the Departments estimate that in 2011, roughly 31 million people will be enrolled in group health plans subject to the prevention provisions in these interim final regulations, growing to approximately 78 million in 2013. The mid-range estimates suggest that approximately 98 million individuals will be enrolled in grandfathered group health plans in 2013, many of which already cover preventive services (see discussion of the extent of preventive services coverage in employer-sponsored plans later in this preamble).

In the individual market, one study estimated that 40 percent to 67 percent of individual policies terminate each year. Because all newly purchased individual policies are not grandfathered, the Departments expect that a large proportion of individual policies will not be grandfathered, covering up to and perhaps exceeding 10 million individuals.

However, not all of the individuals potentially affected by these interim final regulations will directly benefit given the prevalence and variation in insurance coverage today. State laws will affect the number of entities affected by all or some provision of these interim final regulations, since plans, policies, and enrollees in States that already have certain requirements will be affected to different degrees. For instance, 29 States require that health insurance issuers cover most or all recommended immunizations for children. Of these 29 States, 18 States require first-dollar coverage of immunizations so that the insurers pay for immunizations without a deductible and 12 States exempt immunizations from copayments (e.g., $5, $10, or $20 per vaccine) or coinsurance (e.g., 10 percent or 20 percent of charges). State laws also require coverage of certain other preventive health services. Every State except Utah mandates coverage for some type of breast cancer screening for women. Twenty-eight States mandate coverage for cervical cancer screening and 13 States mandate coverage for osteoporosis screening.

Estimation of the number of entities immediately affected by some or all provisions of these interim final regulations is further complicated by the fact that, although not all States require insurance coverage for certain preventive services, many health plans have already chosen to cover these services. For example, most health plans cover most childhood and some adult immunizations contained in the recommendations from the Advisory Committee. A survey of small, medium, and large employers showed that 78 percent to 80 percent of their point of service, preferred provider organization (PPO), and health maintenance organization (HMO) health plans covered childhood immunizations and 57 percent to 66 percent covered influenza vaccines in 2001. All 61 health plans (HMOs and PPOs) responding to a 2005 America’s Health Insurance Plans (AHIP) survey covered childhood immunizations in their best-selling products and almost all health plans (60 out of 61) covered diphtheria-tetanus-pertussis vaccines and influenza vaccines for adults. A survey of private and public employer health plans found that 84 percent covered influenza vaccines in 2002–2003.

Similarly, many health plans already cover preventive services today, but there are differences in the coverage of these services in the group and individual markets. According to a 2009 survey of employer health benefits, over 85 percent of employer-sponsored health insurance plans covered preventive services without having to meet a deductible. Coverage of preventive services does vary slightly by employer size, with large employers being more likely to cover such services than small employers. In contrast, coverage of preventive services is less prevalent and varies more significantly in the individual market. For PPOs,


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**Notes:**

10 See 75 FR 34538 (June 17, 2010).

11 See 75 FR 34538 (June 17, 2010) for a detailed description of the derivation of the estimates for the percentages of grandfathered health plans. In brief, the Departments used 2008 and 2009 Kaiser Family Foundations/Health Research and Educational Trust survey of employers to estimate the proportion of plans that made changes in cost-sharing requirements that would have caused them to relinquish grandfather status if those same changes were made in 2011, and then applied a set of assumptions about how employer behavior might change in response to the incentives created by the grandfather regulations to estimate the proportion of plans likely to relinquish grandfather status. The estimates of changes in 2012 and 2013 were calculated by using the 2011 calculations and assuming that an identical percentage of plan sponsors will relinquish grandfather status in each year.

12 To estimate the number of individuals covered in grandfathered health plans, the Departments extended the analysis described in 75 FR 34538, and estimated a weighted average of the number of employees in grandfathered health plans in the large employer and small employer markets separately, weighting by the number of employees in each employer’s plan. Estimates for the large employer and small employer markets were then combined, using the estimates supplied above that there are 133.1 million covered lives in the large group market, and 43.2 million in the small group market.


14 Of note, State insurance requirements do not apply to self-insured group health plans, whose participants and beneficiaries make up 57 percent of covered employees (in firms with 3 or more employees) in 2009 according to a major annual survey of employers due to ERISA preemption of State insurance laws. See e.g., Kaiser Family Foundation and Health Research and Education Trust, Employer Health Benefits 2009 Annual Survey (2009).


only 66.2 percent of single policies purchased covered adult physicals, while 94.1 percent covered cancer screenings.24

In summary, the number of affected entities depends on several factors, such as whether a health plan retains its grandfather status, the number of new health plans, whether State benefit requirements for preventive services apply, and whether plans or issuers voluntarily offer coverage and/or no cost sharing for recommended preventive services. In addition, participants, beneficiaries, and enrollees in such plans or health insurance coverage will be affected in different ways: Some will newly gain coverage for recommended preventive services, while others will have the cost sharing that they now pay for such services eliminated. As such, there is considerable uncertainty surrounding estimation of the number of entities affected by these interim final regulations.

4. Benefits

The Departments anticipate that four types of benefits will result from these interim final regulations. First, individuals will experience improved health as a result of reduced transmission, prevention or delayed onset, and earlier treatment of disease. Second, healthier workers and children will be more productive with fewer missed days of work or school. Third, some of the recommended preventive services will result in savings due to lower health care costs. Fourth, the cost of preventive services will be distributed more equitably. By expanding coverage and eliminating cost sharing for recommended preventive services, these interim final regulations could be expected to increase access to and utilization of these services, which are not used at optimal levels today.

Nationwide, almost 38 percent of adult residents over 50 have never had a colorectal cancer screening (such as a sigmoidoscopy or a colonoscopy)25 and almost 18 percent of women over age 18 have not been screened for cervical cancer in the past three years.26 Vaccination rates for childhood vaccines are generally high due to State laws requiring certain vaccinations for children to enter school, but recommended childhood vaccines that are not subject to State laws and adult vaccines have lower vaccination rates (e.g., the meningococcal vaccination rate among teenagers is 42 percent).27 Studies have shown that improved coverage of preventive services leads to expanded utilization of these services,28 which would lead to substantial benefits as discussed further below.

In addition, these interim final regulations limit preventive service coverage under this provision to services recommended by the Task Force, Advisory Committee, and HRSA. The preventive services given a grade of A or B by the Task Force have been determined by the Task Force to have at least fair or good evidence that the preventive service improves important health outcomes and that benefits outweigh harms in the judgment of an independent panel of private sector experts in primary care and prevention.29 Similarly, the mission of the Advisory Committee is to provide advice that will lead to a reduction in the incidence of vaccine preventable diseases in the United States, and an increase in the safe use of vaccines and related biological products. The comprehensive guidelines for infants, children, and adolescents supported by HRSA are developed by multidisciplinary professionals in the relevant fields to provide a framework for improving children’s health and reducing morbidity and mortality based on a review of the relevant evidence. The statute and interim final regulations limit the preventive services covered to those recommended by the Task Force, Advisory Committee, and HRSA because the benefits of these preventive services will be higher than others that may be popular but unproven.

Research suggests significant health benefits from a number of the preventive services that would be newly covered with no cost sharing by plans and issuers under the statute and these interim final regulations. A recent article in JAMA stated, “By one account, increasing delivery of just five clinical preventive services would avert 100,000 deaths per year.”31 These five services are all items and services recommended by the Task Force, Advisory Committee, and/or the comprehensive guidelines supported by HRSA. The National Council on Prevention Priorities (NCPP) estimated that almost 150,000 lives could potentially be saved by increasing the 2005 rate of utilization to 90 percent for eight of the preventive services recommended by the Task Force or Advisory Committee.32 Table 2 shows eight of the services and the number of lives potentially saved if utilization of preventive services were to increase to 90 percent.

The author finds that individuals are sensitive to prices for health services—i.e., as copays decline, more services are demanded. See e.g., Sharon Long, “On the Road to Universal Coverage: Impacts of Reform in Massachusetts At One Year,” Health Affairs, Volume 27, Number 4 (June 2008). The author investigated the case of Massachusetts, where coverage of preventive services became a requirement in 2007, and found that for individuals under 300 percent of the poverty line, doctor visits for preventive care increased by 6.1 percentage points in the year after adoption, even after controlling for observable characteristics. Additionally, the incidence of individuals citing cost as the reason for not receiving preventive screenings declined by 2.8 percentage points from 2006 to 2007. In the Massachusetts case, these preventive care services were not necessarily free; therefore, economists would expect a higher differential under these interim final rules because of the price sensitivity of health care usage.

The Task Force defines good and fair evidence as follows. Good: Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes, Fair: Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality or consistency of the individual studies, generalizability to routine practice or indirect nature of the evidence on health outcomes. See http://www.ahrq.gov/clinic/uspstf/ gradespre.htm#drec.

Table 2 shows eight of the services and the number of lives potentially saved if utilization of preventive services were to increase to 90 percent.

25 This differs from the Task Force recommendation that individuals aged 50–75 receive fecal blood testing, sigmoidoscopy, or colonoscopy screening for colorectal cancer.
27 See http://www.cdc.gov/vaccines/stats-survey/ imz-coverage.htm#nis for vaccination rates.
28 See e.g., Jonathan Gruber, The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond, Kaiser Family Foundation (Oct. 2006). This paper examines an experiment in which copays randomly vary across several thousand individuals.
Preventive services’ benefits have also been evaluated individually. Effective cancer screening, early treatment, and sustained risk reduction could reduce the death rate due to cancer by 29 percent. Improved blood sugar control could reduce the risk for eye disease, kidney disease and nerve disease by 40 percent in people with Type 1 or Type 2 diabetes.

Some recommended preventive services both individual and public health value. Vaccines have reduced or eliminated serious diseases that, prior to vaccination, routinely caused serious illnesses or deaths. Maintaining high levels of immunization in the general population protects the un-immunized from exposure to the vaccine-preventable disease, so that individuals who cannot receive the vaccine or who do not have a sufficient immune response to the vaccine to protect against the disease are indirectly protected.

A second type of benefit from these interim final regulations is improved workplace productivity and decreased absenteeism for school children. Numerous studies confirm that ill health compromises worker output and that health prevention efforts can improve worker productivity. For example, one study found that 69 million workers reported missing days due to illness and 55 million workers reported a time when they were unable to concentrate at work because of their own illness or a family member’s illness. Together, labor time lost due to health reasons represents a loss of $260 billion per year. Prevention efforts can help prevent these types of losses. Studies have also shown that reduced cost-sharing for medical services results in fewer restricted-activity days at work, and increased access to health insurance coverage improves labor market outcomes by improving worker health.

Thus, the expansion of benefits and the elimination of cost sharing for preventive services as provided in these

### TABLE 2—LIVES SAVED FROM INCREASING UTILIZATION OF SELECTED PREVENTIVE SERVICES TO 90 PERCENT

<table>
<thead>
<tr>
<th>Preventive service</th>
<th>Population group</th>
<th>Percent utilizing preventive service in 2006</th>
<th>Lives saved annually if percent utilizing preventive service increased to 90 percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular aspirin use</td>
<td>Men 40+ and women 50+</td>
<td>40</td>
<td>45,000</td>
</tr>
<tr>
<td>Smoking cessation advice and help to quit</td>
<td>All adult smokers</td>
<td>28</td>
<td>42,000</td>
</tr>
<tr>
<td>Influenza vaccination</td>
<td>Adults 50+</td>
<td>48</td>
<td>14,000</td>
</tr>
<tr>
<td>Cervical cancer screening in the past 3 years</td>
<td>Women 18–64</td>
<td>37</td>
<td>12,000</td>
</tr>
<tr>
<td>Cholesterol screening</td>
<td>Men 35+ and women 45+</td>
<td>83</td>
<td>620</td>
</tr>
<tr>
<td>Breast cancer screening in the past 2 years</td>
<td>Women 40+</td>
<td>79</td>
<td>2,450</td>
</tr>
<tr>
<td>Chlamydia screening</td>
<td>Women 16–25</td>
<td>67</td>
<td>3,700</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40</td>
<td>30,000</td>
</tr>
</tbody>
</table>

**Source:** National Commission on Prevention Priorities, 2007.

Since financial barriers are not the only reason for sub-optimal utilization rates, population-wide utilization of preventive services is unlikely to increase to the 90 percent level assumed in Table 2 as a result of these interim final regulations. Current utilization of preventive services among insured populations varies widely, but the Departments expect that utilization will increase among those individuals in plans affected by the regulation because the provisions eliminate cost sharing and require coverage for these services. These interim final regulations are expected to increase the take-up rate of preventive services and are likely, over time, to lead physicians to increase their use of these services knowing that they will be covered, and covered with zero copayment. In the absence of data on the elasticity of demand for these specific services, it is difficult to know precisely how many more patients will use these services. Evidence from studies comparing the utilization of preventive services such as blood pressure and cholesterol screening between insured and uninsured individuals with relatively high incomes suggests that coverage increases usage rates in a wide range between three and 10 percentage points, even among those likely to be able to afford basic preventive services out-of-pocket. A reasonable assumption is that the average increase in utilization of these services will be modest, perhaps on the order of 5 to 10 percentage points for some of them. For services that are generally covered without cost sharing in the current market, the Departments would expect minimal change in utilization.

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36 See Modern Infectious Disease Epidemiology by Johan Giesecke 1994, Chapter 18, The Epidemiology of Vaccination.


38 Ibid.


interim final regulations can be expected to have substantial productivity benefits in the labor market.

Illnesses also contribute to increased absenteeism among school children, which could be avoided with recommended preventive services. In 2006, 56 percent of students missed between one and five days of school due to illness, 10 percent missed between six and ten days and five percent missed 11 or more days. Obesity in particular contributes to missed school days: One study from the University of Pennsylvania found that overweight children were absent on average 20 percent more than their normal-weight peers. Studies also show that influenza contributes to school absenteeism, and vaccination can reduce missed school days and indirectly improve community health. These interim final regulations will ensure that children have access to preventive services, thus decreasing the number of days missed due to illness. Similarly, regular pediatric care, including care by physicians specializing in pediatrics, can improve child health outcomes and avert preventable health care costs. For example, one study of Medicaid enrolled children found that when children were up to date for their age on their schedule of well-child visits, they were less likely to have an avoidable hospitalization at a later time.

A third type of benefit from some preventive services is cost savings. Increasing the provision of preventive services is expected to reduce the incidence of illness and, as a result, reduce expenditures on treatment of illness. For example, childhood vaccinations have generally been found to reduce such expenditures by more than the cost of the vaccinations themselves and generate considerable benefits to society. Researchers at the Centers for Disease Control and Prevention (CDC) studying the economic impact of DTaP (diphtheria and tetanus toxoids and acellular Pertussis), Td (tetanus and diphtheria toxoids), Hib (Haemophilus influenza type b), IPV (inactivated poliovirus), MMR (measles, mumps and rubella), Hepatitis B and varicella routine childhood vaccines found that every dollar spent on immunizations in 2001 was estimated to save $5.30 on direct health care costs and $16.50 on total societal costs of the diseases as they are prevented or reduced (direct health care associated with the diseases averted were $12.1 billion and total societal costs averted were $33.9 billion).

A review of preventive services by the National Committee on Prevention Priorities found that, in addition to childhood immunizations, two of the recommended preventive services—discussing aspirin use with high-risk adults and tobacco use screening and brief intervention—are cost-saving on net. By itself, tobacco use screening with a brief intervention was found to save more than $50 per smoker. Another area where prevention could achieve savings is obesity prevention and reduction. Obesity is widely recognized as an important driver of higher health care expenditures. The Task Force recommends children over age six and adults be screened for obesity and be offered or referred to counseling to improve weight status or promote weight loss. Increasing obesity screening and referrals to counseling should decrease obesity and its related costs. If providers are able to proactively identify and monitor obesity in child patients, they may reduce the incidence of adult health conditions that can be expensive to treat, such as diabetes, hypertension, and adult obesity. One recent study estimated that a one-percentage-point reduction in obesity among twelve-year-olds would save $260.4 million in total medical expenditures.

A full quantification of the cost savings from the extension of coverage of preventive services in these interim final regulations is not possible, but to illustrate the potential savings, an assessment of savings from obesity reduction was conducted. According to the CDC, in 2008, 34.2 percent of U.S. adults and 16.9 percent of children were obese (defined as having a body mass index (BMI) of 30.0 or greater). Obesity is associated with increased risk for coronary heart disease, hypertension, stroke, type 2 diabetes, several types of cancer, diminished mobility, and social stigmatization. As a result, obesity is widely recognized as an important driver of higher health care expenditures on an individual and national level.

As described below, the Departments’ analysis assumes that the utilization of preventive services will increase when they are covered with zero copayment, and these interim final regulations are expected to increase utilization of dietary counseling services both among people who currently have the service covered with a copayment and among people for whom the service is not currently covered at all.

Data from the 2009 Kaiser Family Foundation Employer Health Benefits Survey shows that 73 percent of employees with employer-sponsored insurance from a small (< 200 employees) employer do not currently have coverage for weight loss programs, overweight, and obesity.

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45 Fangjun Zhou, Jeanne Santoli, Mark L. Messonnier, Hussain R. Yusuf, Abigail Shefer, Susan Y. Chu, Lance Rodewald, Rafael HARPaz. Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the United States. Archives of Pediatric and Adolescent Medicine 2005; 159(12): 1136–1144. The estimates of the cost savings are based on current immunization levels. The incremental impact of increasing immunization rates is likely to be smaller, but still significant and positive.


51 Red.


compared to 38 percent at large firms.\textsuperscript{56} In the illustrative analysis below, the share of individuals without weight loss coverage in the individual market is assumed to be equal to the share in the small group market.

The size of the increase in the number of individuals receiving dietary counseling or other weight loss services will be limited by current physician practice patterns, in which relatively few individuals who are obese receive physician recommendations for dietary counseling. In one study of patients at an internal medicine clinic in the Bronx, NY, approximately 15 percent of obese patients received a recommendation for dietary counseling.\textsuperscript{57} Similarly, among overweight and obese patients enrolled in the Cholesterol Education and Research Trial, approximately 15 to 20 percent were referred to nutrition counseling.\textsuperscript{58}

These interim final regulations are expected to increase the take-up rate of counseling among patients who are referred to it, and may, over time, lead physicians to increase their referral to such counseling, knowing that it will be covered, and covered without cost sharing. The effect of these interim final regulations is expected to be magnified because of the many other public and private sector initiatives dedicated to combating the obesity epidemic.

In the absence of data on take-up of counseling among patients who are referred by their physicians, it is difficult to know what fraction of the estimated 15 percent to 20 percent of patients who are currently referred to counseling follow through on that referral, or how that fraction will change after coverage of these services is expanded. A reasonable assumption is that utilization of dietary counseling among patients who are obese might increase by five to 10 percentage points as a result of these interim final regulations. If physicians change their behavior and increase the rate at which they refer to counseling, the effect might be substantially larger.

The share of obese individuals without weight loss coverage is estimated to be 29 percent.\textsuperscript{59} It is assumed that obese individuals have health care costs 39 percent above average, based on a McKinsey Global Institute analysis.\textsuperscript{60} The Task Force noted that counseling interventions led to sustained weight loss ranging from four percent to eight percent of body weight, although there is substantial heterogeneity in results across interventions, with many interventions having little long-term effect.\textsuperscript{61}

Assuming midpoint reduction of six percent of body weight, the BMI for an individual taking up such an intervention would fall by six percent as well, as height would remain constant. Based on the aforementioned McKinsey Global Institute analysis, a six percent reduction in BMI for an obese individual (from 32 to around 30, for example) would result in a reduction in health care costs of approximately five percent. This parameter for cost reduction is subject to considerable uncertainty, given the wide range of potential weight loss strategies with varying degrees of impact on BMI, and their interconnectedness with changes in individual health care costs.

Multiplying the percentage reduction in health care costs by the total premiums of obese individuals newly gaining obesity prevention coverage allows for an illustrative calculation of the total dollar reduction in premiums, and dividing by total premiums for the affected population allows for an estimate of the reduction in average premiums across the entire affected population. Doing so results in a potential private premium reduction of 0.05 percent to 0.1 percent from lower health care costs due to a reduction in obesity for enrollees in non-grandfathered plans. This does not account for potential savings in Medicaid, Medicare, or other health programs.

A fourth benefit of these interim final regulations will be to distribute the cost of preventive services more equitably across the broad insured population. Some Americans in plans affected by these regulations currently have no coverage of certain recommended preventive services, and pay for them entirely out-of-pocket. For some individuals who currently have no coverage of certain recommended preventive services, these interim final regulations will result in a large savings in out-of-pocket payments, and only a small increase in premiums. Many other Americans have limited coverage of certain recommended preventive services, with large coinsurance or deductibles, and also make substantial out-of-pocket payments to obtain preventive services. Some with limited coverage of preventive services will also experience large savings as a result of these interim final regulations.

Reductions in out-of-pocket costs are expected to be largest among people in age groups in which relatively expensive preventive services are most likely to be recommended.

5. Costs and Transfers

The changes in how plans and issuers cover the recommended preventive services resulting from these interim final regulations will result in changes in covered benefits and premiums for individuals in plans and health insurance coverage subject to these interim final regulations. New costs to the health system result when beneficiaries increase their use of preventive services in response to the changes in coverage of preventive services. Cost sharing, including coinsurance, deductibles, and copayments, divides the costs of health services between the insurer and the beneficiaries. The removal of cost sharing increases the quantity of services demanded by lowering the direct cost of the service to consumers. Therefore, the Departments expect that the statute and these interim final regulations will increase utilization of the covered preventive services. The magnitude of this effect on utilization depends on the price elasticity of demand.

Several studies have found that individuals are sensitive to prices for health services.\textsuperscript{62} Evidence that consumers change their utilization of preventive services is available from CDC researchers who studied out-of-pocket costs of immunizations for overweight and obesity in primary care,\textsuperscript{63} and from RAND researchers who studied the impact of copay variations on influenza vaccination rates.\textsuperscript{64}

\textsuperscript{56} Kaiser Family Foundation. 2009 Employer Health Benefits Annual Survey. Public Use File provided to CEA; documentation of statistical analysis available upon request. See http://ehbs.kff.org.


\textsuperscript{60} McKinsey Global Institute Analysis provided to CEA.


\textsuperscript{62} See e.g., Jonathan Gruber, The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond, Kaiser Family Foundation (Oct. 2006). This paper examines an experiment in which copays randomly vary across several thousand individuals. The author finds that individuals are sensitive to prices for health services—i.e., as copays decline, more services are demanded.
privately insured children up to age 5 in families in Georgia in 2003, to find that a one percent increase in out-of-pocket costs for routine immunizations (DTaP, IPV, MMR, Hib, and Hop B) was associated with a 0.07 percent decrease in utilization.\textsuperscript{63}

Along with new costs of induced utilization, there are transfers associated with these interim final regulations. A transfer is a change in who pays for the services, where there is not an actual change in the level of resources used. For example, costs that were previously paid out-of-pocket for certain preventive services will now be covered by plans and issuers under these interim final regulations. Such a transfer of costs could be expected to lead to an increase in premiums.

\textbf{a. Estimate of Average Changes in Health Insurance Premiums}

The Departments assessed the impact of eliminating cost sharing, increases in services covered, and induced utilization on the average insurance premium using a model to evaluate private health insurance plans against a nationally representative population. The model is based on the Medical Expenditure Panel Survey data from 2004, 2005, and 2006 on household spending on health care, which are scaled to levels consistent with the CMS projections of the National Health Expenditure Accounts.\textsuperscript{64} This data is combined with data from the Employer Health Benefits Surveys conducted by the Kaiser Family Foundation and Health Research and Education Trust to model a “typical PPO coverage” plan. The model then allows the user to assess changes in covered expenses, benefits, premiums, and induced utilization of services resulting from changes in the characteristics of the plan. The analysis of changes in coverage is based on the average per-person covered expenses and insurance benefits. The average covered expense is the total charge for covered services; insurance benefits are the part of the covered expenses covered by the insurer. The effect on the average premium is then estimated based on the percentage changes in the insurance benefits and the distribution of the individuals across individual and group markets in non-grandfathered plans. The Departments assume that the percent increase for insurance benefits and premiums will be the same. This is based on two assumptions: (1) That administrative costs included in the premium will increase proportionally with the increase in insurance benefits; and (2) that the increases in insurance benefits will be directly passed on to the consumer in the form of higher premiums. These assumptions bias the estimates of premium changes upward. Using this model, the Departments assessed: (1) Changes in cost-sharing for currently covered and utilized services, (2) changes in services covered, and (3) induced utilization of preventive services. There are several additional sources of uncertainty concerning these estimates. First, there is no accurate, granular data on exactly what baseline coverage is for the particular preventive services addressed in these interim final regulations. Second, there is uncertainty over behavioral assumptions related to additional utilization that results from reduced cost-sharing. Therefore, after providing initial estimates, the Departments provide a sensitivity analysis to capture the potential range of impacts of these interim final regulations.

From the Departments’ analysis of the Medical Expenditure Panel Survey (MEPS) data, controlled to be consistent with projections of the National Health Expenditure Accounts, the average person with employer-sponsored insurance (ESI) has $264 in covered expenses for preventive services, of which $240 is paid by insurance, and $24 is paid out-of-pocket.\textsuperscript{65} When preventive services are covered with zero copayment, the Departments expect the average preventive benefit (holding utilization constant) will increase by $24. This is a 0.6 percent increase in insurance benefits and premiums for plans that have relinquished their grandfather status. A similar, but larger effect is expected in the individual market because existing evidence suggests that individual health insurance policies generally have less generous benefits for preventive services than group health plans. However, the evidence base for current coverage and cost sharing for preventive services in individual health insurance policies is weaker than for group health plans, making estimation of the increase in average benefits and premiums in the individual market highly uncertain.

For analyses of changes in covered services, the Departments used the Blue Cross/Blue Shield Standard (BC/BS) plan offered through the Federal Employees Health Benefits Program as an average plan.\textsuperscript{66} Other analyses have used the BC/BS standard option as an average plan as it was designed to reflect standard practice within employer-sponsored health insurance plans.\textsuperscript{67} BC/BS covers most of the preventive services listed in the Task Force and Advisory Committee recommendations, and most of the preventive services listed in the comprehensive guidelines for infants, children, and adolescents supported by HRSA. Not covered by the BC/BS Standard plan are the recommendations for genetic testing for the BRCA gene, adolescent depression screening,\textsuperscript{68} lead testing, autism testing, and oral health screening.\textsuperscript{69}

The Departments estimated the increase in benefits from newly covered services by estimating the number of new services that would be provided instead of the cost of providing the services, and then spread these new costs across the total insured population. The Departments estimated that adding coverage for genetic screening and depression screening would increase insurance benefits an estimated 0.10 percent. Adding lead testing, autism testing, and oral health screening would increase insurance benefits by an estimated 0.02 percent. This results in a total average increase in insurance benefits on these services of 0.12 percent, or just over $4 per insured person. This increase represents a mixture of new costs and transfers, dependent on whether beneficiaries previously would have purchased these services on their own. It is also important to remember that actual plan

\textsuperscript{66}The Blue Cross Blue Shield standard option plan documentation is available online at http://fepblue.org/benefitplans/standard-option/index.html.


\textsuperscript{68}The Task Force recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing and screening of adolescents (12–18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.

\textsuperscript{69}Lead, autism, and oral health screening are from the HRSA comprehensive guidelines.
impacts will vary depending on baseline benefit levels, and that grandfathered health plans will not experience any impact from these interim final regulations. The Departments expect the increase to be larger in the individual market because coverage of preventive services in the individual market is less complete than coverage in the group market, but as noted previously, the evidence base for the individual market is weaker than that of the group market, making detailed estimates of the size of this effect difficult and highly uncertain.

Actuaries use an “induction formula” to estimate the behavioral change in response to changes in the relative levels of coverage for health services. For this analysis, the Departments used the model to estimate the induced demand (the increased use of preventive services). The model uses a standard actuarial formula for induction 1/(1-\alpha P), where \alpha is the “induction parameter” and P is the average fraction of the cost of services paid by the consumer. The induction parameter for physician services is 0.7, derived by the standard actuarial formula that is generally consistent with the estimates of price elasticity of demand from the RAND Health Insurance Experiment and other economic studies.\(^\text{70}\)

Removing cost sharing for preventive services lowers the direct cost to consumers of using preventive services, which induces additional utilization, estimated with the model above to increase covered expenses and benefits by approximately 3%, or 0.04 percent in insurance benefits in group health plans. The Departments expect a similar but larger effect in the individual market, although these estimates are highly uncertain.

The Departments calculated an estimate of the average impact using the information from the analyses described above, using estimates of the number of individuals in non-grandfathered health plans in the group and individual markets in 2011. The Departments estimate that premiums will increase by approximately 1.5 percent on average for enrollees in non-grandfathered plans. This estimate assumes that any changes in insurance benefits will be directly passed on to the consumer in the form of changes in premiums. As mentioned earlier, this assumption biases the estimates of premium change upward.


b. Sensitivity analysis

As discussed previously, there is substantial uncertainty associated with the estimates presented above. To address the uncertainty in the group market, the Departments first varied the estimated change to underlying benefits, to address the particular uncertainty behind the estimate of baseline coverage of preventive services in the group market. The estimate for the per person annual increase in insurance benefits from adding coverage for new services is approximately $4. The Departments considered the impact of a smaller and larger addition in benefits of approximately $2 and $6 per person. To consider the impact of uncertainty around the size of the behavioral change (that is, the utilization of more services when cost sharing is eliminated), the Departments analyzed the impact on insurance benefits if the behavioral change were 15 percent smaller and 15 percent larger.

In the individual market, to accommodate the greater uncertainty relative to the group market, the Departments considered the impact of varying the increase in benefits resulting from cost shifting due to the elimination of cost sharing, in addition to varying the cost of newly covered services and behavioral change.

Combining results in the group and individual markets for enrollees in non-grandfathered plans, the Departments’ low-end is a few tenths of a percent lower than the mid-range estimate of approximately 1.5 percent, and the high-end estimate is a few tenths of a percent higher. Grandfathered health plans are not subject to these interim final regulations and therefore would not experience this premium change.

6. Alternatives Considered

Several provisions in these interim final regulations involved policy choices. One was whether to allow a plan or issuer to impose cost sharing for an office visit when a recommended preventive service is provided in that visit. Sometimes a recommended preventive service is billed separately from the office visit; sometimes it is not. The Departments decided that the cost sharing prohibition of these interim final regulations applies to the specific preventive service as recommended by the guidelines. Therefore, if the preventive service is billed separately from the office visit, it is the preventive service that has cost sharing waived, not the entire office visit.

A second policy choice was if the preventive service is not billed separately from the office visit, whether these interim final regulations should prohibit cost sharing for any office visit in which any recommended preventive service was administered, or whether cost sharing should be prohibited only when the preventive service is the primary purpose of the office visit. Prohibiting cost sharing for office visits when any recommended preventive service is provided, regardless of the primary purpose of the visit, could lead to an overly broad application of these interim final regulations; for example, a person who sees a specialist for a particular condition could end up with a zero copayment simply because his or her blood pressure was taken as part of the office visit. This could create financial incentives for consumers to request preventive services at office visits that are intended for other purposes in order to avoid copayments and deductibles. The increased prevalence of the application of zero cost sharing would lead to increased premiums compared with the chosen option, without a meaningful additional gain in access to preventive services.

A third issue involves health plans that have differential cost sharing for services provided by providers who are in and out of their networks. These interim final regulations provide that a plan or issuer is not required to provide coverage for recommended preventive services delivered by an out-of-network provider. The plan or issuer may also impose cost sharing for recommended preventive services delivered by an out-of-network provider. The Departments considered that requiring coverage by out-of-network providers at no cost sharing would result in higher premiums for these interim final regulations. Plans and issuers negotiate allowed charges with in-network providers as a way to promote effective, efficient health care, and allowing differences in cost sharing in-and-out-of-network enables plans to encourage use of in-network providers. Allowing zero cost sharing for out of network providers could reduce providers’ incentives to participate in insurer networks. The Departments decided that permitting cost sharing for recommended preventive services provided by out-of-network providers is the appropriate option to preserve choice of providers for individuals, while avoiding potentially larger increases in costs and transfers as well as potentially lower quality care.

C. Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes
certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the APA (5 U.S.C. 551 et seq.) and that are likely to have a significant economic impact on a substantial number of small entities. Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act authorize the Secretaries to promulgate any interim final rules that they determine are appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B or title I of ERISA, and part A of title XXVII of the PHS Act, which include PHS Act sections 2701 through 2728 and the incorporation of those sections into ERISA section 715 and Code section 9815.

Moreover, under Section 553(b) of the APA, a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. These interim final regulations are exempt from APA, because the Departments made a good cause finding that a general notice of proposed rulemaking is not necessary earlier in this preamble. Therefore, the RFA does not apply and the Departments are not required to either certify that the rule would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analysis.

Nevertheless, the Departments carefully considered the likely impact of the rule on small entities in connection with their assessment under Executive Order 12866. Consistent with the policy of the RFA, the Departments encourage the public to submit comments that suggest alternative rules that accomplish the stated purpose of the Affordable Care Act and minimize the impact on small entities.

D. Special Analyses—Department of the Treasury

Notwithstanding the determinations of the Department of Labor and Department of Health and Human Services, for purposes of the Department of the Treasury, it has been determined that this Treasury decision is not a significant regulatory action for purposes of Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the APA (5 U.S.C. chapter 5) does not apply to these interim final regulations. For the applicability of the RFA, refer to the Special Analyses section in the preamble to the cross-referencing notice of proposed rulemaking published elsewhere in this issue of the Federal Register. Pursuant to section 7805(f) of the Code, these temporary regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small businesses.

E. Paperwork Reduction Act:
Department of Labor, Department of the Treasury, and Department of Health and Human Services

These interim final regulations are not subject to the requirements of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.) because it does not contain a “collection of information” as defined in 44 U.S.C. 3502 (11).

F. Congressional Review Act

These interim final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and have been transmitted to Congress and the Comptroller General for review.

G. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of $100 million (as adjusted for inflation) by State, local and tribal governments or the private sector. These interim final regulations are not subject to the Unfunded Mandates Reform Act because they are being issued as interim final regulations. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, these interim final regulations have been designed to be the least burdensome alternative for State, local and tribal governments, and the private sector, while achieving the objectives of the Affordable Care Act.

H. Federalism Statement—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have “substantial direct effects” on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments’ view, these interim final regulations have federalism implications, because they have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. However, in the Departments’ view, the federalism implications of these interim final regulations are substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States will enact laws or take other appropriate action resulting in their meeting or exceeding the Federal standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be “construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement” of a Federal standard. The conference report accompanying HIPAA indicates that this is intended to be the “narrowest” preemption of State laws. (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.) States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the Federal requirements are unlikely to “prevent the application of” the Affordable Care Act, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit
the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected State and local officials, including attending conferences of the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis. It is expected that the Departments will act in a similar fashion in enforcing the Affordable Care Act requirements. Throughout the process of developing these interim final regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, the Departments have attempted to balance the States’ interests in regulating health insurance issuers, and Congress’ intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments’ view that they have complied with the requirements of Executive Order 13132. Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to these interim final regulations, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached regulations in a meaningful and timely manner.

V. Recommended Preventive Services as of July 14, 2010

The materials that follow list recommended preventive services, current as of July 14, 2010, that will have to be covered without cost-sharing when delivered by an in-network provider. In many cases, the recommendations or guidelines went into effect before September 23, 2009; therefore the recommended services must be covered under these interim final regulations in plan years (in the individual market, policy years) that begin on or after September 23, 2010. However, there are some services that appear in the figure that are based on recommendations or guidelines that went into effect at some point later than September 23, 2009. Those services do not have to be covered under these interim final regulations until plan years (in the individual market, policy years) that begin at some point later than September 23, 2010. In addition, there are a few recommendations and guidelines that went into effect after September 23, 2009 and are not included in the figure. In both cases, information at http://www.HealthCare.gov/center/ regulations/prevention.html specifically identifies those services and the relevant dates. The materials at http://www.HealthCare.gov/center/ regulations/prevention.html will be updated on an ongoing basis, and will contain the most current recommended preventive services.

A. Recommendations of the United States Preventive Services Task Force (Task Force)

Recommendations of the Task Force appear in a chart that follows. This chart includes a description of the topic, the text of the Task Force recommendation, the grade the recommendation received (A or B), and the date that the recommendation went into effect.

B. Recommendations of the Advisory Committee On Immunization Practices (Advisory Committee) That Have Been Adopted by the Director of the Centers for Disease Control and Prevention

Recommendations of the Advisory Committee appear in four immunization schedules that follow: A schedule for children age 0 to 6 years, a schedule for children age 7 to 18 years, a “catch-up” schedule for children, and a schedule for adults. Immunization schedules are issued every year, and the schedules that appear here are the 2010 schedules. The schedules contain graphics that provide information about the recommended age for vaccination, number of doses needed, interval between the doses, and (for adults) recommendations associated with particular health conditions. In addition to the graphics, the schedules contain detailed footnotes that provide further information on each immunization in the schedule.

C. Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA) for Infants, Children, and Adolescents

Comprehensive guidelines for infants, children, and adolescents supported by HRSA appear in two charts that follow: The Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Panel of the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Text</th>
<th>Grade</th>
<th>Date in Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for abdominal aortic aneurysm</td>
<td>The USPSTF recommends one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked.</td>
<td>B</td>
<td>February 28, 2005</td>
</tr>
<tr>
<td>Counseling for alcohol misuse</td>
<td>The U.S. Preventive Services Task Force (USPSTF) recommends screening and behavioral counseling interventions to reduce alcohol misuse (go to Clinical Considerations) by adults, including pregnant women, in primary care settings.</td>
<td>B</td>
<td>April 30, 2004</td>
</tr>
<tr>
<td>Screening for anemia</td>
<td>The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.</td>
<td>B</td>
<td>May 31, 2006</td>
</tr>
<tr>
<td>Aspirin to prevent CVD: men</td>
<td>The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.</td>
<td>A</td>
<td>March 30, 2009</td>
</tr>
<tr>
<td>Aspirin to prevent CVD: women</td>
<td>The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.</td>
<td>A</td>
<td>March 30, 2009</td>
</tr>
<tr>
<td>Screening for bacteriuria</td>
<td>The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later.</td>
<td>A</td>
<td>July 31, 2008</td>
</tr>
<tr>
<td>Screening for blood pressure</td>
<td>The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults aged 18 and older.</td>
<td>A</td>
<td>December 31, 2007</td>
</tr>
<tr>
<td>Counseling for BRCA screening</td>
<td>The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.</td>
<td>B</td>
<td>September 30, 2005</td>
</tr>
<tr>
<td>Screening for breast cancer (mammography)</td>
<td>The USPSTF recommends mammography for women with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older.</td>
<td>B</td>
<td>September 30, 2002</td>
</tr>
<tr>
<td>Chemoprevention of breast cancer</td>
<td>The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.</td>
<td>B</td>
<td>July 31, 2002</td>
</tr>
<tr>
<td>Counseling for breast feeding</td>
<td>The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.</td>
<td>B</td>
<td>October 31, 2008</td>
</tr>
<tr>
<td>Screening for cervical cancer</td>
<td>The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.</td>
<td>B</td>
<td>January 31, 2003</td>
</tr>
<tr>
<td>Screening for chlamydial infection: non-pregnant women</td>
<td>The U.S. Preventive Services Task Force (USPSTF) recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.</td>
<td>A</td>
<td>June 30, 2007</td>
</tr>
<tr>
<td>Screening for chlamydial infection: pregnant women</td>
<td>The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.</td>
<td>B</td>
<td>June 30, 2007</td>
</tr>
<tr>
<td>Screening for cholesterol abnormalities: men 35 and older</td>
<td>The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders.</td>
<td>A</td>
<td>June 30, 2008</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------</td>
<td>---</td>
<td>----------------</td>
</tr>
<tr>
<td>Screening for cholesterol abnormalities: men younger than 35</td>
<td>The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>B</td>
<td>June 30, 2008</td>
</tr>
<tr>
<td>Screening for cholesterol abnormalities: women 45 and older</td>
<td>The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>A</td>
<td>June 30, 2008</td>
</tr>
<tr>
<td>Screening for cholesterol abnormalities: women younger than 45</td>
<td>The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>B</td>
<td>June 30, 2008</td>
</tr>
<tr>
<td>Screening for colorectal cancer</td>
<td>The USPSTF recommends screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.</td>
<td>A</td>
<td>October 31, 2008</td>
</tr>
<tr>
<td>Chemoprevention of dental caries</td>
<td>The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.</td>
<td>B</td>
<td>April 30, 2004</td>
</tr>
<tr>
<td>Screening for depression: adults</td>
<td>The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.</td>
<td>B</td>
<td>December 31, 2009, identical to a 2002 recommendation</td>
</tr>
<tr>
<td>Screening for depression: adolescents</td>
<td>The USPSTF recommends screening of adolescents (12-19 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.</td>
<td>B</td>
<td>March 30, 2009</td>
</tr>
<tr>
<td>Screening for diabetes</td>
<td>The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.</td>
<td>B</td>
<td>June 30, 2008</td>
</tr>
<tr>
<td>Counseling for diet</td>
<td>The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.</td>
<td>B</td>
<td>January 30, 2003</td>
</tr>
<tr>
<td>Supplementation with folic acid</td>
<td>The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 mcg) of folic acid.</td>
<td>A</td>
<td>May 31, 2009</td>
</tr>
<tr>
<td>Screening for gonorrhea: women</td>
<td>The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors, go to Clinical Considerations for further discussion of risk factors).</td>
<td>B</td>
<td>May 31, 2005</td>
</tr>
<tr>
<td>Prophylactic medication for gonorrhea: newborns</td>
<td>The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum</td>
<td>A</td>
<td>May 31, 2006</td>
</tr>
<tr>
<td>Screening for hearing loss</td>
<td>The USPSTF recommends screening for hearing loss in all newborn infants.</td>
<td>B</td>
<td>July 31, 2008</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>---</td>
<td>-------------</td>
</tr>
<tr>
<td>Screening for hemoglobinopathies</td>
<td>The U.S. Preventive Services Task Force (USPSTF) recommends screening for sickle cell disease in newborns.</td>
<td>A</td>
<td>September 30, 2007</td>
</tr>
<tr>
<td>Screening for hepatitis B</td>
<td>The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.</td>
<td>A</td>
<td>June 30, 2009</td>
</tr>
<tr>
<td>Screening for HIV</td>
<td>The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection (Go to Clinical Considerations for discussion of risk factors).</td>
<td>A</td>
<td>July 31, 2005</td>
</tr>
<tr>
<td>Screening for congenital hypothyroidism</td>
<td>The USPSTF recommends screening for congenital hypothyroidism (CH) in newborns.</td>
<td>A</td>
<td>March 31, 2008</td>
</tr>
<tr>
<td>Iron supplementation in children</td>
<td>The U.S. Preventive Services Task Force (USPSTF) recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia (Go to Clinical Considerations for a discussion of increased risk).</td>
<td>B</td>
<td>May 30, 2006</td>
</tr>
<tr>
<td>Screening and counseling for obesity adults</td>
<td>The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.</td>
<td>B</td>
<td>December 31, 2003</td>
</tr>
<tr>
<td>Screening and counseling for obesity children</td>
<td>The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.</td>
<td>B</td>
<td>January 31, 2010</td>
</tr>
<tr>
<td>Screening for osteoporosis</td>
<td>The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures. (Go to Clinical Considerations for discussion of women at increased risk.)</td>
<td>B</td>
<td>September 30, 2002</td>
</tr>
<tr>
<td>Screening for PKU</td>
<td>The USPSTF recommends screening for phenylketonuria (PKU) in newborns.</td>
<td>A</td>
<td>March 31, 2008</td>
</tr>
<tr>
<td>Screening for Rh incompatibility</td>
<td>The U.S. Preventive Services Task Force (USPSTF) strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</td>
<td>A</td>
<td>February 29, 2004</td>
</tr>
<tr>
<td>Screening for Rh incompatibility 24-28 weeks gestation</td>
<td>The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.</td>
<td>B</td>
<td>February 29, 2004</td>
</tr>
<tr>
<td>Counseling for STIs</td>
<td>The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.</td>
<td>B</td>
<td>October 31, 2008</td>
</tr>
<tr>
<td>Counseling for tobacco use adults</td>
<td>The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.</td>
<td>A</td>
<td>April 30, 2009</td>
</tr>
<tr>
<td>Counseling for tobacco use pregnant women</td>
<td>The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke.</td>
<td>A</td>
<td>April 30, 2009</td>
</tr>
<tr>
<td>Screening for syphilis: non-pregnant persons</td>
<td>The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen persons at increased risk for syphilis infection.</td>
<td>A</td>
<td>July 31, 2004</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>---</td>
<td>----------------</td>
</tr>
<tr>
<td>Screening for syphilis: pregnant women</td>
<td>The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.</td>
<td>A</td>
<td>July 31, 2004</td>
</tr>
<tr>
<td>Screening for visual acuity in children</td>
<td>The USPSTF recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 6 years.</td>
<td>B</td>
<td>May 31, 2004</td>
</tr>
</tbody>
</table>
## Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2010

For those who fall behind or start late, see the catch-up schedule.

### Vaccine ▶ Age ▶

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Age</th>
<th>Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>Birth</td>
<td>5</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>2 doses at ages 2 and 4 months</td>
<td>2</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>3 doses at ages 2, 4, and 4 or 6 months</td>
<td>3</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>2 doses at ages 2 and 4 months</td>
<td>2</td>
</tr>
<tr>
<td>Inactivated Poliovirus</td>
<td>1 dose at age 4 months</td>
<td>1</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td>1 dose at age 12 months</td>
<td>1</td>
</tr>
<tr>
<td>Varicella</td>
<td>2 doses at ages 12 and 18 months</td>
<td>2</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>2 doses at ages 2 and 6 months</td>
<td>2</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>1 dose at age 11-12 months</td>
<td>1</td>
</tr>
</tbody>
</table>

### Inactivated Poliovirus Vaccine (IPV) (Minimum age: 0-8 years)
- The first dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
- If 4 doses are administered prior to age 4 years, a fifth dose should be administered at age 4 through 6 years. See MMWR 2009;58(06):829-30.

### Influenza Vaccine (Seasonal)
- A single-dose (IDR) is recommended. Influenza vaccine (TIV) is recommended for all children aged 6 months to 18 years who are at risk for complications from influenza. See MMWR 2009;58:No. RR-10.

### Varicella Vaccine (Minimum age: 12 months)
- Administer the second dose routinely at age 4 through 6 years. The second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.

### Meningococcal Vaccine
- A single-dose (IDR) is recommended.

### Reference

For more information, please visit the CDC's website on immunization practices: [http://www.cdc.gov/vaccines/pubs/acip-list.htm](http://www.cdc.gov/vaccines/pubs/acip-list.htm).
# Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2010

For those who fall behind or start late, see the schedule below and the catch-up schedule

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age</th>
<th>7–10 years</th>
<th>11–12 years</th>
<th>13–18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, Diphtheria, Pertussis1</td>
<td></td>
<td>Tdap</td>
<td>Tdap</td>
<td></td>
</tr>
<tr>
<td>Human Papillomavirus2</td>
<td></td>
<td>see footnote 2</td>
<td>HPV (3 doses)</td>
<td>HPV series</td>
</tr>
<tr>
<td>Meningococcal3</td>
<td>MCV</td>
<td>MCV</td>
<td>Influenza (Yearly)</td>
<td></td>
</tr>
<tr>
<td>Influenza2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal5</td>
<td>PPSV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A6</td>
<td>Hepatitis A Series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B7</td>
<td>Hep B Series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated Poliovirus8</td>
<td>IPV Series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella9</td>
<td>MMR Series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella90</td>
<td>Varicella Series</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations.**

1. **Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
   - Administer at age 11 or 12 years for those who have completed the recommended childhood DTP/DTap vaccination series and have not received a tetanus and diphtheria toxoid (Td) booster dose.
   - Persons aged 13 through 18 years who have not received Tdap should receive a dose.
   - A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose; however, a shorter interval may be used if pertussis immunity is needed.

2. **Human papillomavirus vaccine (HPV).** (Minimum age: 9 years)
   - Two HPV vaccines are licensed: a quadrivalent vaccine (HPV4) for the prevention of cervical, vaginal and vulvar cancers (in females) and genital warts (in females and males), and a bivalent vaccine (HPV2) for the prevention of cervical cancers in females.
   - HPV vaccines are most effective for both males and females when given before exposure to HPV through sexual contact.
   - HPV4 or HPV2 is recommended for the prevention of cervical precancers and cancers in females.
   - HPV4 is recommended for the prevention of cervical cancers in females.
   - Administer the first dose to females at age 11 or 12 years.
   - Administrate the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
   - Administer the series to females at age 13 through 18 years if not previously vaccinated.
   - HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of acquiring genital warts.

3. **Meningococcal conjugate vaccine (MCV4).**
   - Administer at age 11 or 12 years, or at age 13 through 18 years if not previously vaccinated.
   - Administer to previously unvaccinated college freshmen living in a dormitory.
   - Administer MCV4 to children aged 2 through 10 years with persistent complement component deficiency, anatomic or functional asplenia, or certain other conditions placing them at high risk.
   - Administer to children previously vaccinated with MCV4 or MPSV4 who remain at increased risk after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older). Persons whose only risk factor is living in an on-campus housing are not recommended to receive an additional dose. See MMWR 2009;58:1042–3.

4. **Influenza vaccine (seasonal).**
   - Administer annually to children aged 6 months through 18 years.
   - For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
   - Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
   - For recommendations for use of influenza A (H1N1) 2009 monovalent vaccine. See MMWR 2009;58(No. RR-10).

5. **Pneumococcal polysaccharide vaccine (PPSV).**
   - Administer to children with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See MMWR 1997;46(No RR-8).

6. **Hepatitis A vaccine (HepA).**
   - Administer 2 doses at least 6 months apart.
   - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

7. **Hepatitis B vaccine (HepB).**
   - Administer the 3-dose series to those not previously vaccinated.
   - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 16 years.

8. **Inactivated poliovirus vaccine (IPV).**
   - The first dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
   - Both IPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child’s current age.

9. **Measles, mumps, and rubella vaccine (MMR).**
   - Not previously vaccinated, administer 2 doses or the second dose for those who have received only 1 dose, with at least 28 days between doses.

10. **Varicella vaccine.**
    - For persons aged 7 through 18 years without evidence of immunity (see MMWR 2007;56(No. RR-4)), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
    - For persons aged 7 through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
    - For persons aged 13 years and older, the minimum interval between doses is 28 days.
### Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind—United States • 2010

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child’s age.

#### Persons Aged 4 Months Through 6 Years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
<th>Dose 1 to Dose 2</th>
<th>Dose 2 to Dose 3</th>
<th>Dose 3 to Dose 4</th>
<th>Dose 4 to Dose 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>4 weeks</td>
<td>4 weeks or 6 months</td>
<td>(and at least 16 weeks after first dose)</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
</tr>
<tr>
<td>Tetanus, Diphtheria, Pertussis</td>
<td>4 weeks</td>
<td>4 weeks or 6 months</td>
<td>(and at least 16 weeks after first dose)</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
</tr>
<tr>
<td>Hib</td>
<td>4 weeks</td>
<td>4 weeks or 6 months</td>
<td>(and at least 16 weeks after first dose)</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
</tr>
<tr>
<td>RotaVax</td>
<td>12 weeks</td>
<td>3 months</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Persons Aged 7 Through 18 Years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
<th>Dose 1 to Dose 2</th>
<th>Dose 2 to Dose 3</th>
<th>Dose 3 to Dose 4</th>
<th>Dose 4 to Dose 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, Diphtheria, Pertussis</td>
<td>7 years</td>
<td>4 weeks</td>
<td>(and at least 16 weeks after first dose)</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
</tr>
<tr>
<td>Human Papillomavirus</td>
<td>9 years</td>
<td>6 months</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>12 months</td>
<td>4 weeks</td>
<td>(and at least 16 weeks after first dose)</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
</tr>
<tr>
<td>RotaVax</td>
<td>12 months</td>
<td>3 months</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td>4 weeks</td>
<td>4 weeks or 6 months</td>
<td>(and at least 16 weeks after first dose)</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
</tr>
<tr>
<td>RotaVax</td>
<td>12 months</td>
<td>3 months</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal vaccine</td>
<td>4 years</td>
<td>4 weeks</td>
<td>(and at least 16 weeks after first dose)</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>12 months</td>
<td>6 months</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, and Rubella vaccine</td>
<td>12 months</td>
<td>6 months</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella vaccine</td>
<td>12 months</td>
<td>6 months</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Additional Notes

1. Hepatitis B vaccine (HepB).
   - Administer the 3-dose series to those who have not previously vaccinated.
   - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
2. RotaVax vaccine (RV).
   - The maximum age for the first dose is 14 weeks 6 days. Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
   - The maximum age for the second dose in the series is 8 months 0 days.
   - If RotaVax was administered for the first and second doses, a third dose is not indicated.
3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).
   - The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.
4. Haemophilus influenzae type b conjugate vaccine (Hib).
   - Hib vaccine is not generally recommended for persons aged 5 years or older. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for the diphtheria and tetanus toxoids and acellular pertussis vaccine (DTP) series.
   - If the second dose is PRP-OMP (Pediarix/Hib or Comvax), and the fourth dose is administered at age 11 months or younger, the third (and final) dose should be administered at age 12 months 15 days or later and at least 8 weeks after the second dose.
5. Pneumococcal vaccine.
   - Administer 1 dose of pneumococcal conjugate vaccine (PCV) to all healthy children aged 24 through 59 months who have not received at least 1 dose of PCV on or after age 12 months.
   - For children aged 24 through 59 months with underlying medical conditions, administer 1 dose of PCV if risk factors were present or were diagnosed within 6 months of the first and second doses were received previously.
   - Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions, including chronic hemolytic anemia, at least 8 weeks after the last dose of PCV. See MMWR 1997;46(No. RR-6).
6. Inactivated poliovirus vaccine (IPV).
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months following the previous dose.
   - In the first 6 months of life, minimum age and interval requirements are recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
7. Measles, mumps, and rubella vaccine (MMR).
   - Administer the second dose routinely at age 4 through 6 years. However, the second dose may be administered before age 4, provided that ≥28 days have elapsed since the first dose.
   - If not previously vaccinated, administer 2 doses with at least 28 days between doses.
8. Varicella vaccine.
   - Administer the second dose routinely at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
   - For persons aged 12 months through 15 years, the minimum interval between doses is ≥3 months. However, if the second dose was administered ≥28 days after the first dose, it can be accepted as valid.
   - For persons aged 16 years or older, the minimum interval between doses is ≥28 days.
9. Hepatitis A vaccine (HepA).
   - HepA is recommended for children aged 13 through 18 years who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
10. Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria and acellular pertussis vaccine (Tdap).
    - Doses of Tdap are counted as part of the Td/Tdap series.
    - Tdap should be substituted for a single dose of Td in the catch-up series or as a booster for children aged 10 through 18 years; use Td for other doses.
11. Human papillomavirus vaccine (HPV).
    - Administer the series to females at age 13 through 18 years if not previously vaccinated.
    - Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 1 to 2 and 6 months after the first dose). The minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be administered at least 24 weeks after the first dose.

Information about reporting reactions and immunspongibility is available at [http://www.vacs.hhs.gov](http://www.vacs.hhs.gov) or by telephone, 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at [http://www.cdc.gov](http://www.cdc.gov) (telephone, 800-311-CDCS, INF 800-311-3328) or from the Department of Health and Human Services • Centers for Disease Control and Prevention.
# Recommended Adult Immunization Schedule

## UNITED STATES - 2010

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

### Figure 1. Recommended adult immunization schedule, by vaccine and age group

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>19–26 years</th>
<th>27–49 years</th>
<th>50–59 years</th>
<th>60–64 years</th>
<th>≥65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, diphtheria, pertussis (Td/Tdap)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Td booster every 10 yrs</td>
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<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV)*</td>
<td>3 doses (females)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Varicella*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 doses</td>
</tr>
<tr>
<td>Zoster*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 dose</td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)*</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td>1 dose</td>
</tr>
<tr>
<td>Influenza*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 dose annually</td>
</tr>
<tr>
<td>Pneumococcal (polysaccharide)*</td>
<td></td>
<td></td>
<td></td>
<td>1 or 2 doses</td>
<td>1 dose</td>
</tr>
<tr>
<td>Hepatitis A*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 doses</td>
</tr>
<tr>
<td>Hepatitis B*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 doses</td>
</tr>
<tr>
<td>Meningococcal*</td>
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<td></td>
<td></td>
<td></td>
<td>1 or more doses</td>
</tr>
</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirement and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection) [Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications) No recommendation]

#### Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting terms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-205-3000.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC INFO Contact Center at 800-CDC INFO (800-232-4636) in English and Spanish, 24 hours a day, 7 days a week.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.
### Figure 2. Vaccines that might be indicated for adults based on medical and other indications

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>Td</th>
<th>Tdap</th>
<th>1 dose TIV annually</th>
<th>1 or 2 doses</th>
<th>1 or more doses</th>
<th>1 or 2 doses</th>
<th>1 dose TIV or LAIV annually</th>
<th>1 or 2 doses</th>
<th>1 or more doses</th>
<th>1 or 2 doses</th>
<th>1 or more doses</th>
<th>1 or 2 doses</th>
<th>1 or more doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td></td>
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<tr>
<td>Immune-compromising conditions (excluding human immunodeficiency virus (HIV))</td>
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<tr>
<td>HIV infection**</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>CD4+ T lymphocyte count &lt;200 cells/μL</td>
<td></td>
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<tr>
<td>CD4+ T lymphocyte count ≥200 cells/μL</td>
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<tr>
<td>Diabetes, heart disease, chronic lung disease, chronic alcoholism</td>
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<tr>
<td>Apalasis** (including sickle cell anemia and persistent complement component deficiencies)</td>
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<td></td>
<td></td>
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<tr>
<td>Chronic liver disease</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Kidney failure, end-stage renal disease and receipt of hemodialysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Health-care personnel</td>
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<td></td>
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<td></td>
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</tr>
</tbody>
</table>

*Considered by the Vaccine Injury Compensation Program.

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is currently indicated for adults age 18 years and older, as of January 1, 2010. Recommended vaccination schedules may be used whenever any components of the combination are indicated and when the vaccine is otherwise indicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are rarely used during the year, consult the manufacturers’ package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/ACIP/fact-sheets.html).

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP).
Footnotes
Recommended Adult Immunization Schedule—UNITED STATES · 2010
For complete statements by the Advisory Committee on Immunization Practices (ACIP), visit www.cdc.gov/vaccines/pubs/ACIP-list.htm.

1. Tetanus, diphtheria, and acellular pertussis (Tdap) vaccination

Tdap should replace a single dose of Td for adults aged 11 through 64 years who have not received a dose of Tdap previously.

- Adults with incomplete or incomplete history of primary vaccination series with tetanus and diphtheria toxoid-containing vaccines should begin or complete a primary vaccination series. A primary series for adults in 2 doses of Tdap is recommended in the 3 to 5 year primary series. The booster dose of tetanus and diphtheria toxoid-containing vaccine should be administered to adults who have completed a primary series and if the last vaccination was received more than 10 years previously. Tdap or Td vaccine may be used as indicated.

- A woman is pregnant and received the last Td vaccination ≥10 years previously, administration of Tdap during the second or third trimester is recommended. If the woman received the last Td vaccination ≥10 years previously, administer Tdap during the immediate postpartum period. A single dose of Tdap is recommended for postmenopausal women, close contacts of infants aged ≤12 months, and all health-care personnel with direct patient contact if they have not previously received Tdap. An interval as short as 2 years from the last Td is suggested; shorter intervals can be used. Tdap may be deferred during pregnancy and Td substituted in the immediate postpartum period, or Tdap can be administered instead of Td to a pregnant woman.

Consult the ACIP statement for recommendations for giving Td as prophylaxis in wound management.

2. Human papillomavirus (HPV) vaccination

HPV vaccination is recommended at ages 11 or 12 years with catch-up vaccination at ages 13 through 26 years.

- Ideally, vaccine should be administered before potential exposure to HPV through sexual activity. However, females who are sexually active should still be vaccinated consistent with age-based nonmedical recommendations. Sexually active females who have not been vaccinated with any of the four HPV vaccine types (types 6, 11, 16, 18) or 10 of the two HPV vaccine types (types 6 and 11) who have been vaccinated against both types of HPV vaccine types. HPV 6 or HPV 11 should be administered with persons with a history of genital warts, abnormal Pap test results in the past 2 years, or positive HPV DNA test, because these conditions are not evidence of prior infection with all specific HPV types. HPV may be recommended in males aged 11 through 26 years to reduce their likelihood of acquiring genital warts. HPV may be most effectively administered before exposure to HPV through sexual contact.

- A complete series of either HPV or HPV vaccine is completed in 2 doses. The second dose should be administered 6 months after the first dose; the third dose should be administered 6 months after the first dose.

- Although HPV vaccination is not specifically recommended for persons with the medical indications described in Figure 2, "infectious that might be induced for adolescents based on medical and other indications." It may be administered to those persons because the HPV vaccine is not a live virus vaccine. However, the immune response and vaccine efficacy might be less for persons with the medical indications described in Figure 2 than for persons who do not have the medical indications described who are immunocompetent. Immunocompetent persons are not at increased risk because of occupational exposure, and should not be administered consistent with age-based recommendations.

3. Varicella vaccination

- All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or the second dose if they have received only 1 dose, unless they have a medical contraindication. Special considerations should be given to those who 1) have close contact with persons at high risk for severe disease (e.g., health-care personnel and family contacts of persons with immunocompromising conditions) or 2) are at high risk for exposure or transmission (e.g., teachers, child-care employees, institution staff members, and military personnel).

- Evidence of immunity to varicella in adults includes any of the following: 1) documentation of 2 doses of varicella vaccine at least 4 weeks apart, 2) U.S. born before 1980 (although for health-care personnel and pregnant women, birth before 1980 should not be considered evidence of immunity), 3) history of varicella based on diagnosis or verification of varicella by a health-care provider (the patient reporting a history of or presenting with an abdominal rash, a mild rash, or both, health care providers should seek to obtain an epidemiologic history with a typical varicella rash or a laboratory confirmed case or evidence of laboratory confirmation if it was performed at the time of diagnosis), 4) history of herpes zoster vaccine based on diagnosis or varicella zoster by a health-care provider, 5) laboratory evidence of immunity in relationship of disease.

- Pregnant women should be assured of evidence of varicella immunity. Women who do have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of breastfeeding and before discharge from the health-care facility. The second dose should be administered 4–6 weeks after the first dose.

4. Herpes zoster vaccination

A single dose of zoster vaccine is recommended for adults aged ≥50 years regardless of whether they report a prior episode of herpes zoster. Persons with chronic medical conditions may be vaccinated unless their conditions contraindicates a vaccination.

5. Meningococcal, pneumococcal, rubella (MMR) vaccination

Adults born before 1957 generally are considered immune to meningococcal meningitis and rubella.

- Meningococcal: Adults born during or after 1957 should receive 1 or more doses of meningococcal vaccine if they have 1) a medical contraindication; 2) documentation of vaccination with 1 or more doses of MMR vaccine; 3) laboratory evidence of immunity; or 4) documentation of physician-diagnosed meningococcal disease.

- A second dose of MMR vaccine, administered 4 weeks after the first dose, is recommended for adults who 1) have been recently exposed to measles or are in an outbreak setting; 2) have been vaccinated previously with killed measles vaccine; 3) have been vaccinated with an at-risk adult vaccine during 1967–1994; 4) are students in postsecondary educational institutions; 5) work in a health-care facility; or 6) plan to travel internationally.

- Mumps component: Adults born prior or after 1957 should receive 1 dose of MMR vaccine unless they have 1) a medical contraindication; 2) documentation of vaccination with 1 or more doses of MMR vaccine; 3) laboratory evidence of immunity; or 4) documentation of physician-diagnosed mumps.

- A second dose of MMR vaccine, administered 4 weeks after the first dose, is recommended for adults who 1) live in a community experiencing an mumps outbreak and are in an at-risk age group; 2) are students in postsecondary educational institutions; 3) work in a health-care facility; or 4) plan to travel internationally.

- Rubella component: 1 dose of MMR vaccine is recommended for women who do not have documentation of rubella vaccination, or who lack laboratory evidence of immunity. For women of childbearing age, regardless of birth year, rubella immunity should be determined and women should be vaccinated regarding congenital rubella syndrome. Women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of breastfeeding and before discharge from the health-care facility.

Health care personnel born before 1957 for unvaccinated health care personnel born before 1952 who lack laboratory evidence of measles, mumps, and rubella immunity or laboratory confirmation of disease, health-care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval (for measles and mumps) and 1 dose of MMR vaccine (for rubella), respectively.
6. Seasonal Influenza vaccination

Vaccinate all persons aged ≥50 years and any younger persons who would like to decrease their risk of getting influenza. Vaccinate persons aged 19 through 49 years with any of the following indications:

- Medical chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic renal failure; diabetes mellitus; chronic liver disease; chronic obstructive pulmonary disease; chronic alcoholism; or functional or anatomic asplenia (e.g., sickle cell disease or splenectomy). If a drug-susceptible organism is planned, splenectomy at least 6 weeks before surgery.
- Immunocompromising conditions including chronic renal failure or nephrotic syndrome, and certain immune and developmental fetal toxemia. Vaccinate as close to HIV diagnosis as possible.
- All residents of nursing homes and long-term care facilities and persons who smoke cigarettes. Routine use of PPSV is not recommended for American Indian Alaska natives or persons aged ≥60 years unless they have underlying medical conditions or are PPSV indications. However, public health authorities may recommend recommending PPSV for American Indian Alaska natives and persons aged 50 through 64 years who are living in areas where the risk for invasive pneumococcal disease is increased.

8. Revaccination with PPSV

One-time vaccination after 5 years is recommended for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); and for persons with immunocompromising conditions, for persons aged ≥60 years, one-time vaccination is recommended if they were vaccinated 5 years previously and were younger than age 65 years at the time of primary vaccination.

10. Hepatitis B vaccination

Vaccinate persons with any of the following indications and any person seeking protection from hepatitis A virus (HAV) infection:

- Behavioral: Men who have sex with men and persons who use injection drugs.
- Occupational: Persons working with HAV-infected patients or with HAV in a research laboratory setting.
- Medical: Persons with chronic liver disease and persons who receive clotting factor concentrates.
- Individuals traveling or working in countries that have high or intermediate endemicity of hepatitis A (a list of countries is available at www.cdc.gov/hepatitis/travelcond.htm).
- Those with conditions that are considered personal risk factors (e.g., household contact or regular baby-sitting) with an infant from a country of high or intermediate endemicity during the first 30 days after birth of the adoptive in the United States should consider vaccination. The first dose of the 2-dose hepatitis A vaccine series should be administered at least as soon as adoption is planned, ideally 22 weeks before the arrival of the adoptee.
- Single antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (HAVax, HAV-IPV, or HAV and HIB vaccines), 0 and 6–10 months (Vaccinia), or 0 and 6–18 months (Vaccinia). If the combined hepatitis A and hepatitis B vaccine (Pedvax HIB) is used, administer 3 doses at 0, 1, and 6 months, or 0 and 1 months, respectively, and a 4-dose schedule, administered on days 0, 7, and 21–30 followed by a booster dose at month 12 may be used.

11. Hepatitis C vaccination

Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection:

- Behavioral: Sexually active persons who are at risk for HIV infection, clients and staff members of institutions for persons with developmental disabilities, and international travelers to countries with high or intermediate endemicity of HIV infection (a list of countries is available at www.cdc.gov/travel/cond2.htm).
- Medical: Persons with end-stage renal disease, including patients receiving hemodialysis; persons with HIV infection; and persons with chronic liver disease.
- Household contacts and sex partners of persons with chronic HBV infection, clients and staff members of institutions for persons with developmental disabilities, and international travelers to countries with high or intermediate endemicity of HIV infection (a list of countries is available at www.cdc.gov/travel/cond2.htm).
- Hepatitis C vaccination is recommended for all adults in the following settings: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug abuse treatment and prevention services; health care settings targeting services to injection drug users; and persons who have sex with men or women who have sex with men; or with female sex workers; or in a nonmedical setting with an individual who has had a needlestick wound at an infected individual.
- The second dose should be administered 1 month after the first dose.
- The third dose should be administered at least 6 months after the second dose.
- The fourth dose should be administered at least 1 year after the third dose.
- The fifth dose should be administered at least 2 years after the fourth dose.
11. Meningococcal vaccination

Meningococcal vaccines should be administered to persons with the following indications:

- Adults with anatomic or functional asplenia, or persistent complement component deficiencies.

Other: Final year college students living in dormitories, fraternity house members, residents of skilled nursing facilities, military recruits, and persons who have to or live in countries in which meningococcal disease is hyperendemic or sporadic. (e.g., the "meningitis belt" of sub-Saharan Africa during the dry season [November through June]), particularly those that are in close contact with local populations will be preferred. Vaccination is required for all travelers to Africa during the annual Hajj.

Meningococcal polysaccharide vaccine (MCV4) is preferred for adults with any of the preceding indications who are aged ≥10 years; meningococcal polysaccharide-protein conjugate vaccine (MPCV4) is preferred for adults aged ≥16 years. Revaccination with MCV4 after 5 years is recommended for adults previously vaccinated with MCV4 or MPCV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia). Persons whose only risk factor is living on campus housing are not recommended to receive an additional dose.

12. Selected conditions for which Haemophilus influenzae type b (HiB) vaccine may be used

HiB vaccine generally is not recommended for persons aged ≥15 years. No efficacy data are available on which to base a recommendation concerning use of HiB vaccine for older children and adults. However, studies suggest good immunogenicity in adults who have a history of disease, infection, or HIV infection or who have had a splenectomy. Administering 1 dose of HiB vaccine to these high-risk persons who have not previously received HiB vaccine is not contraindicated.

13. Immuno compromising conditions

Haemophilus influenzae type b generally are acceptable (e.g., immunocompromised, meningococcal, influenza [trivalent influenza vaccine], and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at www.cdc.gov/slo(varsas/v/pdcfor-1h.htm).
<table>
<thead>
<tr>
<th>Individual Characteristics</th>
<th>(0-2 mos)</th>
<th>(3-6 mos)</th>
<th>(7-12 mos)</th>
<th>(13-24 mos)</th>
<th>(2-5 yrs)</th>
<th>(5-8 yrs)</th>
<th>(9-12 yrs)</th>
<th>(13-18 yrs)</th>
<th>(19-24 yrs)</th>
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*Note: X denotes the presence of a characteristic or factor.*
### SACHDNC Recommended Uniform Screening Panel

**CORE CONDITIONS**

(as of February 2010)

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<tr>
<th>ACMG Code</th>
<th>Core Condition</th>
<th>Metabolic Disorder</th>
<th>Endocrine Disorder</th>
<th>Hemoglobin Disorder</th>
<th>Other Disorder</th>
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<td>Propionic academia</td>
<td>Organic acid condition</td>
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<tr>
<td>MUT</td>
<td>Methylmalonic acidemia (methylmalonyl-CoA mutase)</td>
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<td>Cbl A,B</td>
<td>Methylmalonic acidemia (cobalamin disorders)</td>
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<td>IVA</td>
<td>Isovaleric acidemia</td>
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<td>HMG</td>
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<td>Holocarboxylase synthase deficiency</td>
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<td>8-Ketothiolase deficiency</td>
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<td>CUD</td>
<td>Carnitine uptake defect/carnitine transport defect</td>
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<td>MCAD</td>
<td>Medium-chain acyl-CoA dehydrogenase deficiency</td>
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<td>LCHAD</td>
<td>Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency</td>
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<td>TFP</td>
<td>Trifunctional protein deficiency</td>
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<td>ASA</td>
<td>Argininosuccinic aciduria</td>
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<td>CIT</td>
<td>Citrullinemia, type I</td>
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<td>MSUD</td>
<td>Maple syrup urine disease</td>
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<td>HCY</td>
<td>Homocystinuria</td>
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<td>PKU</td>
<td>Classic phenylketonuria</td>
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<td>Tyrosinemia, type I</td>
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<td>Primary congenital hypothyroidism</td>
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<td>Congenital adrenal hyperplasia</td>
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<tr>
<td>Hb SS</td>
<td>S,S disease (Sickle cell anemia)</td>
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<td>Hb S/Th</td>
<td>S, beta-thalassemia</td>
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<tr>
<td>Hb S/C</td>
<td>S,C disease</td>
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<td>Biotinidase deficiency</td>
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<td>GALT</td>
<td>Classic galactosemia</td>
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<tr>
<td>SCID</td>
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<td>CF</td>
<td>Cystic fibrosis</td>
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<tr>
<td>HEAR</td>
<td>Hearing loss</td>
<td></td>
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</table>

1. The selection of these conditions is based on the report “Newborn Screening: Towards a Uniform Screening Panel and System. Genet Med. 2006; 8(5) Suppl. S12-S252” as authored by the American College of Medical Genetics (ACMG) and commissioned by the Health Resources and Services Administration (HRSA).
2. Disorders that should be included in every Newborn Screening Program.
3. The Nomenclature for Conditions is based on the report “Naming and Counting Disorders (Conditions) Included in Newborn Screening Panels” Pediatrics 2006; 117 (5) Suppl. S308-S314
### SACHDNC Recommended Uniform Screening Panel

#### SECONDARY CONDITIONS

(as of February 2010)

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<tr>
<th>ACMG Code</th>
<th>Secondary Condition</th>
<th>Metabolic Disorder</th>
<th>Hemoglobin Disorder</th>
<th>Other Disorder</th>
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<td>Organic acid condition</td>
<td>Fatty acid oxidation disorders</td>
<td>Amino acid disorders</td>
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<td>Cbl C,D</td>
<td>Methylmalonic acidemia with homocystinuria</td>
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<td>MAL</td>
<td>Malonic acidemia</td>
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<tr>
<td>IBG</td>
<td>Isobutyrylglycerinuria</td>
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<td>2MBG</td>
<td>2-Methylbutyrylglycerinuria</td>
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<td>3MGA</td>
<td>3-Methylglutaconic aciduria</td>
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<td>2M3HBA</td>
<td>2-Methyl-3-hydroxybutyric aciduria</td>
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<tr>
<td>SCAD</td>
<td>Short-chain acyl-CoA dehydrogenase deficiency</td>
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<td>M/SCHAD</td>
<td>Medium/short-chain L-3-hydroxyacyl-CoA dehydrogenase deficiency</td>
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<td></td>
<td>T-cell related lymphocyte deficiencies</td>
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1. The selection of these conditions is based on the report “Newborn Screening: Towards a Uniform Screening Panel and System. Genet Med. 2006; 8(5) Suppl: S12-S252” as authored by the American College of Medical Genetics (ACMG) and commissioned by the Health Resources and Services Administration (HRSA).

2. Disorders that can be detected in the differential diagnosis of a core disorder

3. The Nomenclature for Conditions is based on the report “Naming and Counting Disorders (Conditions) Included in Newborn Screening Panels” Pediatrics 2006; 117 (5) Suppl: S306-S314

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### VI. Statutory Authority

The Department of the Treasury temporary regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Health and Human Services interim final regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 USC 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

List of Subjects
26 CFR Part 54
Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590
Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 147
Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

Steven T. Miller,
Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: July 8, 2010

Michael F. Mundaca,
Assistant Secretary of the Treasury (Tax Policy).

Signed this 9th day of July, 2010.

Phyllis C. Borzi,
Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: July 9, 2010

Jay Angoff,
Director, Office of Consumer Information and Insurance Oversight.

Dated: July 9, 2010.

Kathleen Sebelius,
Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Chapter 1

Accordingly, 26 CFR Part 54 is amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by adding an entry for § 54.9815–2713T in numerical order to read in part as follows:

Authority: 26 U.S.C. 7805. * * *
Section 54.9815–2713T also issued under 26 U.S.C. 9833. * * *

Paragraph 2. Section 54.9815–2713T is added to read as follows:

§ 54.9815–2713T Coverage of preventive health services (temporary).

(a) Services—(1) In general. Beginning at the time described in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(ii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(b) Office visits—(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iv) The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Facts. An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) Conclusion. In this Example 1, the plan may not impose any cost-sharing requirements with respect to the separately-
billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2. (i) Facts. Same facts as Example 1. At the time described in paragraph (a)(1) of this section, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.
(ii) Conclusion. In this Example 2, because the treatment is not included in the recommendations under paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

Example 3. (i) Facts. An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.
(ii) Conclusion. In this Example 3, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) Facts. A child covered by a group health plan visits an in-network pediatrician at an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.
(ii) Conclusion. In this Example 4, the service was a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

(3) Out-of-network providers. Nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider. Moreover, nothing in this section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(4) Medical management. Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the recommendation or guideline.

(5) Services not described. Nothing in this section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A plan or issuer may impose cost-sharing requirements for a treatment not described in paragraph (a)(1) of this section, even if the treatment results from an item or service described in paragraph (a)(1) of this section.

(b) Timing—In general. A plan or issuer must provide coverage pursuant to paragraph (a)(1) of this section for plan years that begin on or after September 23, 2010, or, if later, for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued. (2) Changes in recommendations or guidelines. A plan or issuer is not required under this section to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section after the recommendation or guideline is no longer described in paragraph (a)(1) of this section. Other requirements of Federal or State law may apply in connection with a plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective.

(c) Recommendations not current. For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(d) Effective/applicability date. The provisions of this section apply for plan years beginning on or after September 23, 2010. See §54.9815–1251T for determination of the applicability of this section to grandfathered health plans (providing that these rules regarding coverage of preventive health services do not apply to grandfathered health plans).

(e) Expiration date. This section expires on July 12, 2013 or on such earlier date as may be provided in final regulations or other action published in the Federal Register.

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

■ 29 CFR Part 2590 is amended as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 1. The authority citation for Part 2590 continues to read as follows:


Subpart C—Other Requirements

■ 2. Section 2590.715–2713 is added to subpart C to read as follows:

§2590.715–2713 Coverage of preventive health services.

(a) Services—(1) In general. Beginning at the time described in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been
adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention; (iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and (iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(2) Office visits—(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iv) The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Facts. An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) Conclusion. In this Example 1, the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2. (i) Facts. Same facts as Example 1. As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.

(ii) Conclusion. In this Example 2, because the treatment is not included in the recommendation paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

Example 3. (i) Facts. An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 3, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) Facts. A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, or otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 4, the service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

(3) Out-of-network providers. Nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider. Moreover, nothing in this section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(4) Reasonable medical management. Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the recommendation or guideline.

(5) Services not described. Nothing in this section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A plan or issuer may impose cost-sharing requirements for a treatment not described in paragraph (a)(1) of this section, even if the treatment results from an item or service described in paragraph (a)(1) of this section.

(b) Timing—(1) In general. A plan or issuer must provide coverage pursuant to paragraph (a)(1) of this section for plan years that begin on or after September 23, 2010, or, if later, for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) Changes in recommendations or guidelines. A plan or issuer is not required under this section to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section after the recommendation or guideline is no longer described in paragraph (a)(1) of this section. Other requirements of Federal or State law may apply in connection with a plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective.

(c) Recommendations not current. For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(d) Applicability date. The provisions of this section apply for plan years beginning on or after September 23, 2010. See § 2590.715–1251 of this Part for determining the application of this section to grandfathered health plans (providing that these rules regarding coverage of preventive health services do not apply to grandfathered health plans).
DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Subtitle A

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR part 147, added May 13, 2010, at 75 FR 27138, effective July 12, 2010, as follows:

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

1. The authority citation for part 147 continues to read as follows:

Authority: Sections 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

2. Add §147.130 to read as follows:

§147.130 Coverage of preventive health services.

(a) Services—(1) In general. Beginning at the time described in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(2) Office visits—(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iv) The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Facts. An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 1, the service was not billed as a separate charge and was billed as part of an office visit. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 2. (i) Facts. An individual covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. While visiting the provider, the child receives an additional item or service that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) Conclusion. In this Example 2, the service was not billed as a separate charge and was billed as part of an office visit. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 3. (i) Facts. A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement for the office visit charge.

(3) Out-of-network providers. Nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider. Moreover, nothing in this section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(4) Reasonable medical management. Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the recommendation or guideline.

(5) Services not described. Nothing in this section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or from denying coverage for items and services that are not recommended by the United States Preventive Services Task Force or that advisory committee, or under those guidelines. A
plan or issuer may impose cost-sharing requirements for a treatment not described in paragraph (a)(1) of this section, even if the treatment results from an item or service described in paragraph (a)(1) of this section.

(b) Timing—(1) In general. A plan or issuer must provide coverage pursuant to paragraph (a)(1) of this section for plan years (in the individual market, policy years) that begin on or after September 23, 2010, or, if later, for plan years (in the individual market, policy years) that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) Changes in recommendations or guidelines. A plan or issuer is not required under this section to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section after the recommendation or guideline is no longer described in paragraph (a)(1) of this section. Other requirements of Federal or State law may apply in connection with a plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days’ advance notice to an enrollee before any material modification will become effective.

(c) Recommendations not current. For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(d) Applicability date. The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. See §147.140 of this Part for determining the application of this section to grandfathered health plans (providing that these rules regarding coverage of preventive health services do not apply to grandfathered health plans).

[FR Doc. 2010–17242 Filed 7–14–10; 11:15 am]
BILLING CODE 4830–01–P; 4510–29–P; 4210–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2010–0646]

RIN 1625–AA00

Safety Zone; Transformers 3 Movie Filming, Chicago River, Chicago, IL

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone on the Chicago River near Chicago, Illinois. This zone is intended to restrict vessels from a portion of the Chicago River due to the filming of a major motion picture. This temporary safety zone is necessary to protect the surrounding public and vessels from the hazards associated with the different types of stunts that will be performed during the filming of this movie.

DATES: Effective Date: this rule is effective in the CFR from July 19, 2010 until 9 p.m. on July 19, 2010. This rule is effective with actual notice for purposes of enforcement beginning 7 a.m. on July 16, 2010.

ADDRESSES: Documents indicated in this preamble as being available in the docket are part of docket USCG–2010–0646 and are available online by going to http://www.regulations.gov, inserting USCG–2010–0646 in the “Keyword” box, and then clicking “search.” They are also available for inspection or copying at the Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary rule, contact or email BM1 Adam Kraft, U.S. Coast Guard Sector Lake Michigan, at 414–747–7154 or Adam.D.Kraft@uscg.mil. If you have questions on viewing the docket, call Renee V. Wright, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION:

Regulatory Information

The Coast Guard is issuing this temporary final rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when an agency for good cause finds that those procedures are “impracticable, unnecessary, or contrary to the public interest.” Under U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to the fact that the application for this event was not submitted to our office in time to allow for publishing an NPRM. Based on the hazards associated with the filming of this major motion picture, delaying the publication of this rule to provide for a comment would be contrary to public interest as immediate action is necessary to protect the public.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the Federal Register because delaying the effective date would be contrary to the public interest since immediate action is needed to protect the public and the event would be over by the time the 30 day period is completed.

Basis and Purpose

This temporary safety zone is necessary to protect vessels from the hazards associated with the filming of the major motion picture, Transformers 3. The combination of congested waterways and the filming of dangerous stunts taking place on or near the water pose serious risks of injury to persons and property. As such, the Captain of the Port, Sector Lake Michigan, has determined that the filming of this motion picture does pose significant risks to public safety and property and that a temporary safety zone is necessary.

Discussion of Rule

The safety zone will encompass all U.S. navigable waters of the Chicago River between the Michigan Avenue Bridge, 41°53′20″ N. 087°37′27″ W. and the North Columbus Drive Bascule Bridge, 41°53′19″ N. 087°37′13″ W. [DATUM: NAD 83].

All persons and vessels shall comply with the instructions of the Coast Guard Captain of the Port, Sector Lake Michigan, or his or her on-scene representative. Entry into, transiting, or anchoring within the safety zone is prohibited unless authorized by the Captain of the Port, Sector Lake Michigan, or his or her on-scene representative. The Captain of the Port, Sector Lake Michigan, or his or her on-scene representative may be contacted via VHF Channel 16.

The safety zone will encompass all U.S. navigable waters of the Chicago River between the Michigan Avenue Bridge, 41°53′20″ N. 087°37′27″ W. and the North Columbus Drive Bascule Bridge, 41°53′19″ N. 087°37′13″ W. [DATUM: NAD 83].

All persons and vessels shall comply with the instructions of the Coast Guard Captain of the Port, Sector Lake Michigan, or his or her on-scene representative. Entry into, transiting, or anchoring within the safety zone is prohibited unless authorized by the Captain of the Port, Sector Lake Michigan, or his or her on-scene representative. The Captain of the Port, Sector Lake Michigan, or his or her on-scene representative may be contacted via VHF Channel 16.