NHeLP
NATIONAL HEALTH LAW PROGRAM

Q&A on Preventive Services for Women Coverage Requirements (Updated)[1]

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The Affordable Care Act (ACA) requires many health insurance plans to provide coverage for certain women's preventive health services without cost-sharing. These requirements go into effect for plan or policy years beginning on or after August 1, 2012 and are already providing millions of women with new or improved access to evidence-based preventive health care without the significant barriers associated with cost-sharing. This Q&A addresses some of the most common questions surrounding the women's preventive services requirements.

Q1 - Where do the women's preventive services coverage requirements come from?

A. The ACA added Section 2713 to the Public Health Services Act, requiring certain health insurance plans to cover a broad array of evidence-based preventive health services without cost-sharing.[3] To ensure that women's unique preventive health needs are addressed, the ACA required the Health Resources and Services Administration (HRSA) to develop guidelines that articulate the specific women's health benefits to be included in the coverage requirement.[4] HRSA commissioned the Institute of Medicine (IOM) to provide evidence-based recommendations, and the IOM recommended the inclusion of eight women's preventive health benefits to supplement existing coverage requirements. HRSA adopted the IOM's recommendations, and the resulting guidelines (HRSA Guidelines) can be found at: http://www.hrsa.gov/womensguidelines/.

[1] This update of NHeLP's August 2012 factsheet includes guidance from the Frequently Asked Questions released February 20, 2013. U.S. Dep'ts of Labor, Health & Human Serv., & Treasury, *Frequently Asked Questions about Affordable Care Act Implementation Part XII* (February 20, 2013), *available at* http://www.dol.gov/ebsa/faqs/faq-aca12.html#5 (hereinafter *February 2013 FAQ*).
[3] The term "cost-sharing" includes copays, coinsurance and deductibles, but does not include premiums.
[4] 42 U.S.C. § 300gg-13(a)(4) (ACA § 1001, adding § 2713 of the Public Health Services Act).

Q2 - What benefits are included in the women's preventive services coverage requirements?

A. The chart below outlines the required benefits.

Well-woman preventive care visits to obtain recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care	All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity
High-risk human papillomavirus (HPV) DNA testing in women with normal cytology results	Annual counseling on sexually transmitted infections for all sexually active women
Annual counseling and testing for HIV for all sexually active women[5]	Screening for gestational diabetes
Comprehensive breastfeeding support and counseling and costs for renting breastfeeding equipment for the duration of breastfeeding[6]	Annual screening and counseling for interpersonal and domestic violence[7]

Q3 - What plans are subject to these requirements?

A. Individual and group (i.e. employee) health insurance plans ("plans"), including self-insured employer plans, must adhere to these coverage requirements unless they are "grandfathered." The requirements apply to plans sold inside and outside of the health insurance exchanges.

Q4 - What are grandfathered plans?

A. Grandfathered plans are plans that existed on March 23, 2010 and have not substantially changed. A plan loses its grandfathered status if it: significantly cuts or reduces benefits; raises charges associated with co-insurance, co-payments or deductibles beyond permissible amounts; lowers employer contributions by more than 5 percent; or adds or decreases annual limits on what the insurer will pay.[8] If an individual enrolled in her current insurance plan on or before March 23, 2010 or enrolls in a group plan that has been in existence since March 23, 2010, she might be in a grandfathered plan. Grandfathered group plans may enroll new enrollees without foregoing their grandfathered status. For a plan to maintain grandfathered status, it must disclose that

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[5] While the guidelines require annual counseling and "screening" for HIV for all sexually active women, the February 2013 FAQ clarifies that in this context, "screening" means testing. *February 2013 FAQ, supra* note 1, Q13.

[6] The February 2013 FAQ clarifies that the required breastfeeding support and equipment must be covered without cost-sharing for the duration of breastfeeding. *Id*, at Q20.

[7] The February 2013 FAQ contains more information about domestic violence screening, as well as suggested tools and training materials. *Id.* at Q11.

[8] 45 C.F.R. 147.140(g).

status in materials that describe covered benefits to enrollees.[9] Grandfathered plans are not subject to the preventive services requirements.

Q5 - What contraceptive drugs, devices and services do plans have to cover under these requirements?

A. Plans subject to the women's preventive services requirements must cover sterilization procedures, patient education and contraceptive counseling, and the full range of FDA-approved contraceptive methods. These include oral contraceptive pills, intrauterine devices (IUDs), contraceptive implants, injectables, and barrier methods (e.g. diaphragm). Plans must also cover over-the-counter FDA-approved methods such as contraceptive sponges, spermicides, and emergency contraception without cost-sharing, although they must be prescribed by a health care provider.

In addition to all FDA-approved methods and procedures, plans must also cover services related to follow-up and management of side effects, counseling for continued adherence, and removal of devices (e.g. IUDs and implants) without cost-sharing.[10]

Q6 - Are plans required to cover prenatal care beyond the specific pregnancy-related preventive services listed in the guidelines?[11]

A. Yes. The women's preventive services requirements define well-woman visits to include recommended preventive services that are age and developmentally appropriate, *including preconception and prenatal care*. The HRSA Guidelines refer to the IOM's full report for further clarification about what services are covered during a well-woman preventive service visit. With regard to prenatal care, the IOM report provides that:

> The recommended content of the [well-woman prenatal care] visit includes specific tests and procedures (e.g., blood pressure, weight, urine test, uterine size and fetal heart rate assessment, glucose tolerance testing, and screening for specific sexually transmitted infections and genetic or developmental conditions), as well as topics for counseling and guidance (e.g., tobacco avoidance and nutrition).[12]

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[9] 45 C.F.R. 147.140(a)(2).

[10] *February 2013 FAQ, supra* note 1, Q16.

[11] For a more detailed explanation of the women's preventive services prenatal coverage requirements, see NHeLP's factsheet on the subject, *available at* http://www.healthlaw.org/images/stories/Well-Women_Visits_&_Prenatal_Care_under_the_ACA.pdf.

[12] Inst. of Medicine of the Nat'l Academies, *Clinical Preventive Services for Women: Closing the Gaps* 133 (2011), *available at* www.iom.edu/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf.

Plans subject to these requirements must cover – without cost-sharing – as many prenatal well-woman visits as a woman's provider determines are medically appropriate due to her health status, health needs, and other risk factors.[13]

Q7 - Are religious employers exempt from these requirements in their employee health plans?

A. A narrow category of nonprofit religious institutions are exempt from the *contraceptive* coverage requirement in the HRSA guidelines (these institutions are *not* exempt from the remainder of the women's preventive services requirements). The exemption is available to a nonprofit church or close church affiliate if it primarily employs *and* serves persons who share its religious tenets, and the purpose of the institution is the inculcation of religious values.[14] New regulations proposed by HHS, described below, would slightly modify the definition of entities that qualify for an exemption.

A broader category of nonprofit religiously-affiliated organizations have a safe harbor that allows them not to comply with the *contraceptive* coverage requirement in their employee or student health plans until August 1, 2013. To qualify for this extension, an organization must be a nonprofit whose employee or student health plans have not covered contraception for religious reasons at any point since February 10, 2012. Qualified organizations must complete a certification form, and their health plans must notify covered employees and students during the first open enrollment period on or after August 1, 2012.

At the time of this factsheet's publication, the Departments of Labor, Health and Human Services (HHS), and the Treasury are developing regulations that will offer some non-exempted nonprofit religiously-affiliated employers and universities that object to contraceptive coverage an "accommodation." As proposed, the accommodation will provide enrollees with separate contraceptive coverage without cost-sharing, but without the involvement of the religiously-affiliated non-profit organization.[15]

In addition, over 50 lawsuits have been filed by for-profit companies and non-profit religiously-affiliated organizations who are demanding full exemptions from the

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[13] The February 2013 FAQ clarifies that a woman's clinician determines the required frequency of well-woman visits, rather than insurance plan or issuer. *February 2013 FAQ, supra* note 1, Q10.

[14] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725 (Feb. 15, 2012).

[15] Coverage of Certain Preventive Services under the Affordable Care Act, 78 Fed. Reg. 8456 (proposed Feb. 6, 2013) (to be codified at 29 C.F.R. pt. 2590; 45 C.F.R. pts. 147, 148, 156).

contraceptive coverage requirement. If those entities prevail in the courts, their employees and students will be denied contraceptive coverage.[16]

NHeLP will continue to advocate against further encroachment of religious exemptions or accommodations from these and other coverage requirements. The HRSA preventive services for women guidelines are evidence-based and reflect prevailing standards of medical care. If employers are permitted to deny benefits to their employees based on their own personal beliefs, many women will receive substandard health coverage simply because of where they work or go to school.[17]

Q8 - When should women enrolled in plans subject to the preventive services requirements expect to begin receiving these benefits without cost-sharing?

A. Although the women's preventive services requirements went into effect on August 1, 2012, plans did not have to begin providing enrollees with the required coverage until the next policy year (for individual insurance plans) or plan year (for group insurance plans) beginning on or after August 1, 2012. Enrollees should check with their insurance providers to learn the dates of their particular plan or policy years.

Q9 - How frequently will women be able to access these services without cost-sharing?

A. The frequency at which plans must cover the women's preventive services without cost-sharing varies by service. For example, counseling and testing for HIV must be covered annually for all sexually active women, while testing for HPV must be covered no more frequently than every three years for women ages 30 and above. Well-woman visits must be covered at least annually, but additional visits must be provided without cost-sharing if a woman's clinician determines that more frequent visits are necessary (see Q6, above). Plans subject to the requirements must cover contraceptive methods as prescribed. The frequency requirements for each covered service can be found in the HRSA preventive services for women guidelines, available at http://www.hrsa.gov/womensguidelines/.

Q10 - Are plans permitted to impose *any* cost-sharing related to these services?

A. Plans subject to the women's preventive services requirements must cover these benefits without cost-sharing so long as a woman receives the services from a provider in the plan's network.[18] However, cost-sharing is allowed for some related *office visits*,

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[16] NHeLP has filed several amicus briefs in the for-profit cases. A full litigation docket with links to filings is available at http://www.healthlaw.org/images/stories/ACA_Litigation_Constitutional_Challenges.pdf.
[17] For more information about religious exemptions and medical standards of care, visit NHeLP's Standards of Care Project at http://www.healthlaw.org/index.php?option=com_content&id=473.
[18] 45 C.F.R. 147.130(a)(3).

depending on how the provider tracks and bills the insurance plan for the visit.[19] The two instances when health insurance plans can impose cost-sharing for office visits related to the required preventive services are:

1. If a provider bills or tracks a required preventive service separately from the office visit during which the preventive service was received, a plan may impose cost-sharing with respect to the office visit (but not for the preventive service itself); or

2. If the primary purpose of the office visit is something other than the provision of the preventive service, a plan may impose cost-sharing with respect to the office visit (but not for the preventive service itself).

Q11 - What if a plan does not have any in-network providers to provide a particular required preventive service?

A. If a plan does not have a provider in its network who can provide a particular required preventive service, then the plan must cover the service or item without cost-sharing when provided by an out-of-network provider.[20]

Q12 - Are plans allowed to use "medical management" to control access to the required preventive services?[21]

A. Yes, but within limits. Medical management is broadly understood to encompass insurer practices that aim "to control costs and promote efficient delivery of care."[22] Health insurance plans are only permitted to use "reasonable" medical management techniques to determine the frequency, method, treatment or setting for the required preventive services to the extent not already specified in the HRSA Guidelines.[23]

The rules governing the required preventive services do not define medical management or the conditions under which it might be reasonable. They do, however, offer some guidance and important limitations. For example, federal guidance notes that delivering multiple prevention and screening services at a single visit is a reasonable and permissible medical management technique.[24] Plans also may impose cost-sharing for a brand name prescription drug when an equivalent generic version of the drug is available. However, in this instance, the rules require plans to provide a waiver process

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[19] 45 C.F.R. 147.130(a)(2).
[20] *February 2013 FAQ, supra* note 1, Q3.
[21] For more information, see NHeLP's issue brief on medical management and access to contraception, available at http://www.healthlaw.org/images/stories/Medical_Management_and_Access_to_Contraception.pdf.
[22] *See id. at* Q14.
[23] 45 CFR § 147.130(a)(4).
[24] *February 2013 FAQ, supra* note 1, Q9.

to accommodate any enrollee for whom the enrollee's provider (in consultation with the enrollee) determines the generic substitution is medically inappropriate.[25]

Particularly in the context of contraception, commonly used medical management techniques such as prior authorization and step therapy requirements that limit the availability of methods should not be considered reasonable and permissible under the law. Insurance-related delays in access or denials of a chosen method not only deny women control of their reproductive autonomy, they also increase risk of unintended pregnancy and therefore undermine the intent of the coverage requirement.

Q13 - Are plans required to cover any other preventive services without cost-sharing?

A. In addition to the required women's preventive services, § 2713 lists three additional categories of preventive services that non-grandfathered group and individual insurance plans must cover without cost-sharing:

1. Services with "A" or "B" ratings from the US Preventive Services Taskforce;

2. Immunizations recommended by the Centers for Disease Control and Prevention; and

3. Preventive services in separate HRSA guidelines for infants, children and adolescents.

These categories include additional preventive health services that are critical for women, such as osteoporosis and cervical cancer screening, mammography, and tobacco cessation.[26] These categories went into effect in 2010 and an estimated 54 million individuals received expanded coverage of preventive services in 2011 alone.[27]

[25] *Id.* at Q14.
[26] A full list of required preventive services is available at http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html (last visited April 11, 2013).
[27] Assistant Sec'y for Planning and Evaluation, U.S. Dept. of Health & Human Serv., *Fifty-four Million Additional Americans are Receiving Preventive Services Coverage Without Cost-Sharing under the Affordable Care Act* (2012), *available at* http://aspe.hhs.gov/health/reports/2012/PreventiveServices/ib.shtml.