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NHeLP Breaks Down Preventive Health Services Standards & Contraceptive Coverage under the ACA

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The Affordable Care Act (ACA) will dramatically expand access to affordable family planning options for women. It promises to do so through two preventive services standards that apply to consumers differently depending on the type of health coverage they receive. The first is contained in Department of Health and Human Services' (HHS) women's preventive services guidelines ("WPS Guidelines"). The second is a preventive services requirement included in the Essential Health Benefits (EHB) – the ACA's fundamental benefits standard that will form the foundation for a wide range of coverage options.

Though both are "preventive services" requirements, and in spite of significant overlap, the WPS Guidelines and the EHB standard are distinct. The WPS Guidelines will extend coverage of critical preventive services that include contraception, without cost-sharing, to many women covered in the private insurance market both inside and outside of state health insurance Exchanges. The EHB standard will apply to many of the same private plans, but will also extend to enrollees in public insurance programs. Though early guidance assures that both standards will cover the same services, the EHB standard is still being defined and many questions remain. This paper explains these two standards and analyzes how they differ, interact, and affect contraceptive coverage in different types of private and public health insurance.

Section I. Women's Preventive Services Guidelines ("WPS Guidelines")

1. Statutory Source

The ACA requires private health insurance plans to cover certain preventive services without cost-sharing.[1] These preventive services fall into four broad categories:

1. evidence-based screenings and counseling services rated highly by the United States Preventive Services Task Force (USPSTF);
2. routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. certain preventive care and screenings for infants, children and adolescents; and,
4. **preventive care and screening services for women, to be identified in comprehensive guidelines supported by HRSA**.[2]

This final category was intended to close otherwise significant gaps in comprehensive preventive health care for women and reduce cost-sharing barriers to services critical for women's health.

[1] Patient Protection and Affordable Care Act ("ACA") § 1001, 42 U.S.C. § 300gg-13 (amending § 2713 of the Public Health Services Act).
[2] ACA § 1001, 42 U.S.C. § 300gg-13(a)(1)-(4) (amending § 2713 of the Public Health Services Act).

2. Implementation Process

The requirements under the first three categories of preventive services went into effect on September 23, 2010. HHS commissioned the Institute of Medicine (IOM) to provide evidence-based recommendations on specific preventive measures that meet women's unique health needs and help keep women healthy. The IOM Committee identified gaps in the coverage of preventive health services not already addressed by the first three categories. Out of this process, the IOM developed eight recommendations necessary to supplement existing coverage requirements and fulfill the promise of comprehensive access to preventive health care for women.[3]

HHS adopted these recommendations and issued guidelines ("WPS Guidelines") requiring plans subject to their requirements to cover preventive services consistent with the IOM's recommendations, without cost-sharing, beginning on August 1, 2012.[4]

3. Content

The WPS Guidelines require coverage of eight services without the imposition of cost-sharing mechanisms such as deductibles or copayments:

1. well-woman visits that include age and developmentally appropriate preventive services, including prenatal and preconception care;
2. screening for gestational diabetes;
3. testing for human papillomavirus (HPV);
4. counseling for sexually transmitted infections (STIs);
5. counseling and screening for human immune-deficiency virus (HIV);
6. breastfeeding support, supplies, and counseling;
7. screening and counseling for interpersonal and domestic violence; and
8. **all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity**.[5]

While insurers subject to these requirements must provide coverage for each of these preventive services, there may be limits and variation according to service and patient needs.[6]

4. Types of Coverage Affected

The WPS Guidelines apply to all private plans except plans with "grandfathered" status (i.e. plans that existed before March 23, 2010 and have not made certain significant changes to coverage).[7] Beginning August 1, 2012, all other private individual, large group, small group, and self-insured plans will be required to provide coverage of these preventive health services for women without cost-sharing, unless a religious exemption applies (discussed below).

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[3] INST. OF MED. ("IOM"), CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 163-168 (prepublication ed.) (2011).
[4] U.S. DEP'T OF HEALTH & HUMAN SERVICES, WOMEN'S PREVENTIVE SERVICES: REQUIRED HEALTH PLAN COVERAGE GUIDELINES, *available at* http://www.hrsa.gov/womensguidelines/.
[5] *Id.*
[6] *Id*.
[7] ACA § 1251, 42 U.S.C. 18011; 26 CFR § 54.9815-1251T; 29 CFR § 2590.715-1251; 45 CFR § 147.140.

5. Limitations and Concerns

While the WPS Guidelines are evidence-based and responsive to women's health needs, some important limits to their application exist. First, they are gender-specific and therefore do not extend coverage requirements or cost-sharing protections to men. Additionally, the WPS Guidelines' coverage requirements do not directly apply to several important types of coverage in addition to grandfathered plans. For example, the WPS Guidelines do not directly apply to Medicaid, though Medicaid has other mechanisms for requiring some of these same preventive services without cost-sharing, including family planning services.[8] Additionally, the WPS Guidelines do not directly apply to the Basic Health Program created under the ACA.[9]

The regulations that implement the WPS Guidelines allow utilization controls, billing practices, and benefit design and plan administration decisions by insurers that may, in practice, weaken the promise of free and unfettered access to these services. For example, the regulations permit plans to use "reasonable medical management" techniques to impose limitations and determine "the frequency, method, treatment, or setting" of coverage to the extent not specified in the guidelines.[10] Further, the regulations allow cost-sharing if an included preventive service is performed by an out-of-network provider, if the service is billed as a part of an office visit that was not scheduled primarily for the purpose of providing that service, or for an office visit that is billed separately from the service itself.[11] In addition, the WPS Guidelines explicitly limit the frequency of contraceptive coverage to "as prescribed," causing some concern that a prescription requirement may prevent or complicate coverage of over-the-counter family planning supplies.[12] The extent to which these limitations will carve away the guidelines' protections remains to be seen, but advocates should pay attention to these issues as the roll-out takes place after August 1, 2012.

Finally, special rules for religious employers threaten to unfairly deprive women of these evidence-based preventive health services simply because of where they work. In February 2012, HHS adopted a religious employer exemption that will allow a narrow category of religious employers, primarily houses of worship, to refuse to cover contraception in their employer-sponsored health plans.[13] At the same time, the Obama Administration announced an "accommodation" that will allow an even broader category of non-profit religiously-affiliated employers, such as hospitals and universities, to refuse to provide contraceptive coverage in

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[8] *See* 42 U.S.C. § 1396d(a)(4)(C) (requiring family planning services and supplies to be covered in Medicaid programs); 42 U.S.C. § 1396u-7(b)(7) (added by ACA § 2303(C) and referring to § 1396d(a)(4)(C)) (extending family planning services and supplies requirement to Medicaid benchmark plans).

[9] Section 1331 of the ACA gives states the option to establish a Basic Health Program. This option permits states to offer one or more "Basic Health" insurance plans to individuals with incomes between 133% and 200% FPL instead of offering them coverage through an Exchange. Lawfully present non-citizens with incomes under 133% FPL who are not eligible for Medicaid are also eligible for state BHPs. ACA § 1331, 42 U.S.C. 18051.

[10] 45 C.F.R. § 147.130(a)(4) (2012); 29 C.F.R. § 2590.715-2713(a)(4) (2012).

[11] 45 C.F.R. § 147.130(a)(2)-(3) (2012); 29 C.F.R. § 2590.715-2713(a)(2)-(3) (2012).

[12] *See* U.S. DEP'T OF HEALTH & HUMAN SERVICES, *supra* note 4.

[13] 45 C.F.R. § 147.130(a)(1)(iv) (2012).

their employer-sponsored plans.[14] The proposed accommodation pledges to ensure that affected employees are able to obtain contraceptives at no additional cost directly from their insurance carriers.[15] At the time of this paper's publication, HHS is seeking comments to assist in the development of rules to govern this accommodation.[16] Separate HHS guidance created a one-year "safe harbor" period, allowing non-exempted non-profit organizations whose plans have not covered contraceptive services for religious reasons at any time after February 10, 2012 to delay implementation of the required coverage until August 1, 2013.[17] HHS intends to finalize regulations relating to the accommodation before the end of this safe harbor period.[18]

Section II. Essential Health Benefits Preventive Services Requirement

1. Statutory Source

Essential Health Benefits (EHB) are the minimum benefits that must be offered in most public and private health insurance packages offered through a wide range of coverage options that are created or expanded under the ACA. The contents of the EHB will have a tremendous impact on millions of individuals' access to comprehensive health services.

The ACA charges HHS with defining the EHB standard. The EHB standard must include benefits that are equal in scope to the "typical employer plan" and cover a list of ten required categories of services.[19] One of these categories is "preventive and wellness services and chronic disease management."[20] The ACA does not define "preventive and wellness services" or list illustrative or specific services to be included. Nor does the statute directly incorporate other preventive services standards such as the WPS Guidelines, although HHS has indicated through pre-regulatory guidance that the EHB will include these preventive services (discussed in detail below).

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[14] Remarks on Preventive Health Care Insurance Coverage and an Exchange with Reporters, Daily Comp. Pres. Docs., 2012 DCPD No. 201200091; Office of the Press Secretary, Executive Office of the President, Fact Sheet: Women's Preventive Services and Religious Institutions (2012), *available at* http://www.whitehouse.gov/the-press-office/2012/02/10/fact-sheet-women-s-preventive-services-and-religious-institutions.

[15] *Id.*

[16] Women's Preventive Services under the Affordable Care Act, 77 Fed. Reg. 16501 (advance notice of proposed rulemaking March 21, 2012).

[17] U.S. DEP'T OF HEALTH & HUMAN SERVICES, GUIDANCE ON THE TEMPORARY ENFORCEMENT SAFE HARBOR FOR CERTAIN EMPLOYERS, GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE ISSUERS (2012), *available at* http://cciio.cms.gov/resources/files/Files2/02102012/20120210-Preventive-Services-Bulletin.pdf.

[18] Women's Preventive Services under the Affordable Care Act, 77 Fed. Reg. 16501, 16503 (advance notice of proposed rulemaking March 21, 2012).

[19] ACA § 1302(b)(2)(A), 42 U.S.C. § 18022(b)(2)(A).

[20] ACA § 1302(b)(1)(I), 42 U.S.C. § 18022(b)(1)(I).

2. Implementation Process

a. Institute of Medicine Recommendations

HHS again commissioned the Institute of Medicine (IOM) to recommend criteria for determining what must be included in the EHB benefits package.[21] The IOM issued a report with its recommendations in September 2011. The report, *Essential Health Benefits: Balancing Coverage and Cost*, did not recommend specific services to be covered, but instead focused on developing criteria and policy foundations to guide HHS in determining and updating the contents of the EHB package.[22] Unfortunately, the IOM recommendations placed heavy emphasis on cost as the primary determinant of benefits, supported state flexibility in defining EHB standards, and suggested that HHS define "typical employer" plans as *small* employer plans in determining the scope of the EHB package.[23]

b. EHB Bulletin

On December 16, 2011, HHS released a pre-regulatory Bulletin outlining an intended regulatory approach for determining the EHB services.[24] In the Bulletin, HHS proposes that each state select a benchmark from the existing private insurance market to serve as a "reference plan" that will define the scope of services for that state's particular EHB package. Under the Bulletin's proposed approach, each state may select its benchmark plan from the following four categories:

- the three largest small group plans in the state;
- the three largest state employee health plans;
- the three largest federal employee health plans in the state; or
- the largest HMO plan offered in the state's commercial market.[25]

The "largest" plans in each of these categories are to be determined by enrollment. This approach, if followed, will result in different EHB standards in each of the states, rather than one strong national floor of defined benefits. The resulting state variation in coverage will make it exceedingly difficult to identify or monitor the specific contents of the EHB into the future.[26]

According to the Bulletin, if a state's selected benchmark is missing any of the 10 required categories of benefits, such as preventive and wellness services, the state must supplement the

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[21] Note that the IOM Essential Health Benefits committee is not the same IOM committee that developed recommendations to inform the WPS Guidelines.
[22] INST. OF MED. ("IOM"), ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST (prepublication ed.) (2011).
[23] For more about the IOM report and NHeLP's analysis, see NHeLP's December 2, 2011 response letter to HHS, *available at:* http://healthlaw.org/images/stories/NHeLP%20Letter%20EHB%2012.02.2011.pdf.
[24] U.S. DEP'T OF HEALTH & HUMAN SERVICES, ESSENTIAL HEALTH BENEFITS BULLETIN (2011), *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. Note that the Bulletin focuses on the definition of covered services and does not discuss other aspects of plan design such as actuarial value or cost-sharing.
[25] *Id*. at 9.
[26] For more information, *see* NHeLP Comments in Response to the EHB Bulletin (2012), *available at* http://www.healthlaw.org/images/stories/NHELP_EHB%20Comments_1.31.12_FINAL.pdf.

plan using the benefits offered in that category by another of the benchmark options.[27] The category of services will only be included in the EHB to the extent already covered in an existing private market plan. If existing coverage of a particular category of services is insufficient, the state's EHB standard will be similarly limited.

The Bulletin also suggests that health insurance issuers will have flexibility to adjust and swap out benefits, so long as they continue to offer a consistent level of overall coverage of the 10 mandated categories.[28] This flexibility is proposed within a particular benefit category (exchanging one preventive health service for another, for example) and between benefit categories (removing a preventive health service, but adding an emergency service, for example). NHeLP is concerned that this insurer flexibility has the potential to allow insurers to alter benefits packages in a way that disfavors certain populations (for example, individuals with specialized health needs).[29]

The Bulletin also addresses state mandates (state laws that require insurance plans in the state market to cover certain benefits). During the transitional years of 2014 and 2015, if a state chooses a benchmark plan that is subject to state mandates, those mandates will be included in the state's EHB package.[30] If the state chooses a benchmark plan that does not include the state's benefit mandates (for example, a federal employee health plan that is not subject to state mandates and does not cover some or all of the services mandated by state law), the state must cover the cost of any mandated services that fall outside of the EHB package.[31] Ultimately, states may be placed in an untenable financial situation or have an incentive to drop mandates that provide valuable coverage to individuals.

c. EHB Frequently Asked Questions

HHS released answers to frequently asked questions (FAQ) about the EHB Bulletin on February 17, 2012. In that document, HHS responded that several preventive services standards, including the WPS guidelines, "will be a part of the EHB."[32] This is an important step in ensuring that these critical preventive services are acknowledged as "essential," reinforced through the EHB standard, and extended to a broader population than is subject directly to the WPS Guidelines' requirements. However, the FAQ does not provide any additional details about how these services will be incorporated or when HHS will issue further guidance. Additionally, the FAQ is silent as to whether HHS will incorporate the cost-sharing protection and religious refusal provision of the WPS Guidelines into the EHB requirements.

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[27] U.S. DEP'T OF HEALTH & HUMAN SERVICES, *supra* note 24, at 10.
[28] *Id.* at 12.
[29] NHeLP, *supra* note 26.
[30] U.S. DEP'T OF HEALTH & HUMAN SERVICES, *supra* note 24, at 9-10. Federal employee health plans are not subject to state mandates. The extent to which state employee health plans are subject to state mandates varies according to state law.
[31] *Id.*
[32] U.S. DEP'T OF HEALTH & HUMAN SERVICES, FREQUENTLY ASKED QUESTIONS ON ESSENTIAL HEALTH BENEFITS BULLETIN 5 (2012), http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

3. Content

As mentioned above, because HHS has declined to articulate a minimum floor of benefits, the precise content of state EHB packages is unknown. However, because the EHB FAQ indicates that the EHB will incorporate preventive services that include those articulated in the WPS Guidelines, the preventive and wellness services category of the EHB should cover a reliable and comprehensive set of contraceptive services.

4. Types of Coverage Affected

The EHB package defines the minimum requirements for a broad array of health coverage types. The EHB will form the minimum benefits package that all levels of Qualified Health Plans (QHPs) participating in the insurance Exchanges and non-grandfathered plans sold in the small group and individual markets outside of the Exchanges must cover.[33] The WPS Guidelines also apply to these plans.

Unlike the WPS Guidelines, the EHB standard will also directly apply to millions of new Medicaid enrollees, and as discussed above, HHS has indicated that the EHB will include the same services articulated in the WPS Guidelines. Starting January 1, 2014, Medicaid will cover up to an additional 16 million new enrollees with incomes below 138 percent of the federal poverty level (FPL). The majority of these newly eligible recipients will be covered through Medicaid "benchmark" plans.[34] Medicaid Benchmark plans are not synonymous with the benchmark options articulated in the EHB Bulletin; however, the EHB standard forms the minimum coverage requirement of Medicaid Benchmark plans. [35]

Additionally, the EHB will form the minimum coverage standard for the Basic Health Program (BHP).

5. Limitations and Concerns

The EHB requirements do not apply to grandfathered plans outside of the Exchanges, categories of Medicaid coverage that existed prior to the passage of the ACA (other than Medicaid Benchmark Plans), self-insured employer-sponsored plans, or large employer health plans prior to 2017.[36]

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[33] ACA § 1301(a)(1)(B), 42 U.S.C. § 18021(a)(1)(B); ACA § 1334(c)(1)(A), 42 U.S.C. § 18054(c)(1)(A); ACA §1201 (amending section 2707 of the Public Health Service Act, codified as 42 U.S.C. 300gg–6).

[34] Medicaid Benchmark benefits were created in Medicaid through the 2005 Deficit Reduction Act (DRA) as an optional alternative to the standard state Medicaid benefits package. Instead of being based on the traditional Medicaid covered services, they can be based on any one of several 'benchmark' standards established by the DRA. Social Security Act § 1937(b)(1), 42 U.S.C. § 1396u-7(b)(1). The ACA expands the role of Medicaid Benchmarks by making Benchmark benefits the default benefits package for the Medicaid Expansion population, although the ACA now requires the Benchmarks to also include the EHB. ACA § 2001(a)(2)(A), 42 U.S.C. § 1396a(k)(1). Medicaid benchmark plans may offer more limited services than for enrollees receiving "full-scope" Medicaid.

[35] ACA §2001(c), 42 U.S.C. § 1396u–7(b)(5).

[36] In 2017, states may allow issuers of large group plans to offer QHPs in the large group market through the Exchange. ACA § 1312(f)(2)(B), 42 U.S.C. § 18032.

Additionally, as mentioned above, the specific services to be included in the EHB standards remain largely unknown and will likely vary between states. It does not appear from pre-regulatory guidance that HHS intends to require a strong national floor of minimum comprehensive benefits, even for the ten categories of required benefits. States and insurers will have flexibility in defining what services will be offered, potentially allowing the design of benefit packages that do not meet the needs of sicker and higher-needs populations. Although HHS has indicated that the EHB will include the same services covered in the WPS Guidelines and other preventive care requirements, the specifics of this inclusion and the application of cost-sharing protections and religious employer exemptions remain unclear.

The treatment of state coverage mandates in the EHB Bulletin is particularly important in the context of family planning and women's preventive health. Currently, 28 states have laws mandating the coverage of contraception.[37] If HHS does not allow permanent incorporation of state mandates into the EHB standard, it could result in a dilution of currently covered family planning services. The FAQ's affirmation that HHS intends to require all EHB standards to incorporate the WPS Guidelines' required services, which include contraception, is an important step in maintaining current access to family planning.

Section III. Analysis by Coverage Type

As discussed above, the WPS Guidelines and EHB preventive services requirement are two separate standards with important differences between them. Contraceptive coverage is guaranteed for many women without cost-sharing through the WPS Guidelines directly. While the same services are incorporated into the EHB, it is still unknown whether all of the WPS protections (e.g., prohibition on cost-sharing) and limitations (e.g., religious employer exemption) will also apply. Potential vulnerabilities and gaps in contraceptive coverage still exist. This section summarizes the application of the WPS Guidelines, the EHB package, and additional family planning coverage requirements to Medicaid Benchmark plans, Qualified Health Plans (QHP), and Basic Health Programs (BHP).

1. Medicaid Benchmark Plans

WPS Guidelines: The WPS Guidelines do not apply directly to Medicaid Benchmark plans.

EHB Package: Medicaid Benchmark plans must cover the EHB package. Because HHS guidance indicates that the EHB package will include the services covered in the WPS Guidelines, women in Medicaid Benchmark plans will receive contraceptive coverage through this standard.

Other Independent Family Planning Requirement: The ACA expands the statutory coverage requirements of the Medicaid Benchmark benefit to include family planning services and

[37] For more information on state laws requiring contraceptive coverage, *see* NAT'L CONFERENCE OF STATE LEGISLATURES, INSURANCE COVERAGE FOR CONTRACEPTION LAWS, http://www.ncsl.org/default.aspx?tabid=14384 (last visited Jan. 9, 2012).

supplies.[38] These family planning services and supplies must be provided without cost-sharing.[39]

Result: Medicaid Benchmark plans must cover contraception through the EHB. In addition, because of Medicaid statutory requirements, enrollees in Medicaid Benchmark plans will receive coverage of family planning services and supplies without cost-sharing, regardless of whether the EHB standard is defined to include cost-sharing protections.

2. Qualified Health Plans (QHP)

WPS Guidelines: The WPS Guidelines apply to new QHPs.[40] Women enrolled in these plans will benefit from the Guidelines' strong contraceptive mandate without cost-sharing, unless they are employed by the narrow class of employers (primarily houses of worship) that qualify for an exemption.

EHB Package: All new QHPs must cover the EHB package, which includes the preventive services required under the WPS Guidelines.

Other Independent Family Planning Requirements: QHPs will be operating in state insurance markets and may be subject to existing state coverage mandates that require contraceptive coverage.

Result: QHPs will be required through both the WPS Guidelines and the EHB standard to include contraceptive coverage. This coverage is guaranteed without cost-sharing under the WPS Guidelines regardless of whether the EHB package includes the same cost-sharing protections. However, women employed by a narrow class of employers (primarily houses of worship) will not benefit from the WPS Guidelines' contraceptive coverage guarantees. It is not yet known whether other religious employers will also be exempted from the EHB contraceptive coverage requirement.

3. Basic Health Program (BHP)

WPS Guidelines: The WPS Guidelines do not apply directly to BHPs.

EHB Package: BHP plans must cover the EHB package, which includes the preventive services required under the WPS Guidelines.[41]

Other Independent Family Planning Requirements: No additional independent family planning coverage requirements appear to apply explicitly to the BHP.

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[38] ACA § 2303(c), 42 U.S.C. § 1396u-7(b)(7).
[39] 42 U.S.C. §§ 1396o(a)-(c); § 1396o-1. *See also* CMS, Dear State Medicaid Director (June 16, 2006), *available at*: www.cms.hhs.gov/smdl/downloads/SMD061606.pdf. A small exception allows nominal copayments for non-preferred prescription drugs.
[40] NHeLP is currently analyzing whether a grandfathered plan could qualify as a QHP without losing grandfathered status. If this is possible, the WPS Guidelines will not apply to grandfathered QHPs.
[41] ACA § 1331(b)(2), 42 U.S.C. § 18051(b)(2).

Result: The BHP is the only coverage category discussed in this paper that will rely solely on the EHB package for guaranteed contraceptive coverage, further emphasizing the importance of robust coverage and the inclusion of cost-sharing protections for this low-income population.

Section IV. Conclusion

While reproductive health and family planning advocates celebrate the strong contraception requirement without cost-sharing in the WPS Guidelines and oppose further encroachment of religious exemptions, it is important to continue to advocate for the same coverage in the EHB standard. Important pre-regulatory guidance from HHS clarifies that all of the services included in the WPS Guidelines will also be included in the EHB. This is a welcome step in the right direction and advocates should continue to push for the same clear incorporation of the WPS Guidelines' cost-sharing protections in the EHB context. The protections contained in the EHB will be especially important for enrollees in BHP plans, who may not otherwise receive guaranteed coverage of contraceptive services without cost-sharing unless such a guarantee is included in the EHB. The definition of the EHB package offers an opportunity to recognize family planning services as the essential health benefits that they are, and ensure that coverage standards defined and implemented under the ACA are as consistent and mutually reinforcing as possible, increasing the likelihood that health reform will succeed in standardizing quality comprehensive health care for all.

ACA Preventive Services Requirements and Contraceptive Coverage

	HHS Women's Preventive Services ("WPS") Guidelines	Essential Health Benefits (EHB) Preventive Services Requirement
Source	The ACA adds § 2713(a)(4) to the Public Health Services Act (PHSA) to require certain private health insurance plans to cover evidence-informed preventive care and screening services for women, as determined through agency guidelines. This is one of four preventive services categories required to be covered without cost-sharing under § 2713.	The EHB package is generally defined in § 1302 of the ACA. Section 1302(b)(1) outlines ten categories of services that must be included in the EHB. One of these is "preventive and wellness services and chronic disease management."
Implementation	• HHS commissioned the Institute of Medicine (IOM) to provide guidance on the women's preventive health services required under § 2713(a)(4). The IOM issued recommendations in July 2011. • In August 2011, HHS issued guidelines that require most non-grandfathered private plans to cover services consistent with the IOM recommendations, beginning on August 1, 2012. • In February 2012, HHS finalized a rule exempting a narrow category of religious employers from the Guidelines' contraceptive coverage requirement and announced that non-exempted non-profit religious employers do not have to comply until August 1, 2013. • An "accommodation" allowing a broader category of religious employers to refuse direct coverage of contraceptives is under development.	• HHS commissioned IOM to provide recommendations. In September 2011, the IOM issued a report that recommended criteria and policy foundations to guide HHS in defining and updating the EHB. • In December 2011, HHS released a pre-regulatory Bulletin that outlined an intended regulatory approach to defining the EHB. • In February 2012, HHS issued answers to frequently asked questions (FAQ) about the EHB Bulletin. • Future regulatory guidance is expected, but the timeline is unknown.
Content	The following must be covered without cost-sharing: • Well-woman visits; • Screening for gestational diabetes; • Testing for human papillomavirus (HPV); • Counseling for sexually transmitted infections (STIs); • Counseling and screening for HIV; • Breastfeeding support, supplies, and counseling; • Screening and counseling for domestic violence; • **All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.**	• HHS has not finalized the specific content of the benefit package, though pre-regulatory guidance suggests that HHS will define the contents according to varying private market benchmark plans selected at the state level. • The ACA requires that the benefits package be equal in scope to the "typical employer plan," and include ten additional categories of required benefits, including "preventive and wellness services and chronic disease management." • In the FAQ, HHS indicated that the preventive services required under § 2713 of the PHSA, including the WPS Guidelines, will be included in the EHB.

	HHS Women's Preventive Services ("WPS") Guidelines	Essential Health Benefits (EHB) Preventive Services Requirement
Types of Coverage Affected	• All new Qualified Health Plans participating in the insurance Exchanges. • All new plans in the group and individual markets outside of the Exchanges, including self-insured employer-sponsored plans.	• All Qualified Health Plans participating in the new insurance Exchanges. • All new plans sold in the small group and individual markets outside of the Exchanges. • Medicaid Benchmark and Basic Health Programs (BHP).
Limitations & Concerns	• Do not directly apply to Basic Health Programs (BHP) or Medicaid. • Gender-specific (the guidelines do not apply to men). • Subject to billing practices, medical management, and plan administration decisions by insurers that may, in practice, weaken access to these services. • Refusal clause allowing group health plans offered by certain religious employers an exemption from the contraception requirement.	• Specific content of the EHB package remains unclear. • Pre-regulatory guidance from HHS allows state and insurer flexibility in selecting and designing EHB packages, models scope of EHB coverage after existing private market plans, and fails to set national minimum coverage requirements. • Future of existing state coverage mandates is unclear. • Incorporation of the WPS cost-sharing protections uncertain. • Potential for a refusal clause similar to the one contained in WPS Guidelines.