Access to Preventive Health Care for Women in the Health Care Law:
Frequently Asked Questions

The new health care law makes preventive care more accessible and affordable to millions of Americans. This is especially important to women, who are more likely than men to avoid needed health care, including preventive care, because of cost. To help address these cost barriers and make sure all women have access to preventive health care, one section of the new health care law requires all new and non-grandfathered private insurance plans to cover a wide range of preventive services without co-payments or other cost sharing requirements.[1]

I heard about this new law that requires health plans to cover preventive care like mammograms and contraceptives. What is it and what does it require?
The new health care law (The Affordable Care Act) requires certain preventive health services and screenings to be covered in all new health insurance plans without cost-sharing. This means that, for the preventive health care services included, you will not be charged a co-payment for the services, and the costs of the services will not be applied to your deductible.

Which preventive services will new plans have to cover?
The law bases the set of preventive services and screenings that all new health insurance plans must cover without cost-sharing on four sets of expert recommendations: (1) services recommended by the U.S. Preventive Services Task Force, and given an "A" or "B" rating; (2) all vaccinations recommended by the Center for Disease Control's Advisory Committee on Immunization Practices; (3) a set of evidence-based services for infants, children and adolescents based on guidelines developed by the American Academy of Pediatrics and the Department of Health and Human Services; and, (4) a set of additional evidence-based preventive services for women recommended by the Institute of Medicine and supported by the Health Resources and Services Administration.[2]

The U.S. Preventive Services Task Force recommendations include a number of preventive services that are of critical importance for women, including:

(1) Mammograms every 1-2 years for women over 40;
(2) Cervical cancer screening;
(3) Smoking and alcohol cessation programs for adults;
(4) A wide range of prenatal screenings and tests;
(5) Diabetes and blood pressure screening and counseling; and
(6) Depression screening for adolescents and adults.[3]

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[1] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2713, 124 Stat. 119, 131 (2010) (to be codified at 42 U.S.C. § 300gg-13).
[2] *Id*.
[3] For a complete list of the USPSTF recommendations, please visit http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

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The Advisory Committee on Immunization Practices includes a number of vaccines important to women, including vaccines for HPV, the flu, and Hepatitis, among others.

On August 1, 2011, the Department of Health and Human Services announced the additional women's preventive services that all new plans must cover with no cost sharing. These include:

(1) Lactation consultation and supplies;
(2) Screening and counseling for interpersonal and domestic violence;
(3) Screening for gestational diabetes;
(4) DNA co-testing for HPV;
(5) Counseling regarding sexually transmitted infections including HIV;
(6) Screening for HIV;
(7) Contraceptive methods and counseling; and
(8) Well woman visits.[4]

For more information on contraceptive coverage, please see Contraceptive Coverage in the New Health Care Law: Frequently Asked Questions.

Does this mean I won't have to pay anything for preventive services including the services in the new list announced in August?
You will be able to get the included preventive services at no out of pocket costs, as the full cost will be covered by your monthly premium. While some plans covered preventive services with no cost sharing requirements before the new rule, many only paid a portion of the cost, while the consumer would have to pay the additional cost out of pocket, in the form of a co-payment or co-insurance. This new rule means that the full range of services will be *fully covered* by insurance plans. Plans will not be able to charge extra payments for these services, such as co-payments or deductibles.

Won't this make my monthly premiums go up?
While we can't say for certain, it is unlikely. There is significant evidence that many of the preventive services included on this list, such as tobacco cessation, obesity reduction services, immunizations and contraceptives, are actually cost-saving.

When do these new requirements take effect?
Many private insurance plans have already started providing some of the preventive services—those recommended by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the American Academy of Pediatrics—as of January 1, 2011. The requirement that all new plans cover the additional Women's Preventive Services has not yet taken effect. The official start date is August 1, 2012, but since most plan changes take effect at the beginning of a new plan year, the requirements will be in effect for most plans on January 1, 2013. School health plans, which often begin their health plan years around the beginning of the school year, will see the benefits of the August 1st start date.

[4] Coverage of Preventive Health Services, 47 CFR § 147.130 (2011), *and* Women's Preventive Services: Required Health Plan Coverage Guidelines (Aug. 1, 2011), http://www.hrsa.gov/womensguidelines/.

I get health insurance through my employer, how do I know if my plan is new and if these requirements apply to my plan?
Health plans that existed before the health care law are considered "grandfathered" into the new system under the health care law.[5] Grandfathered plans don't have to follow the new preventive services cost sharing rules. This means that the plan can continue to operate just as it has until it makes significant changes to the plan. These changes include: cutting benefits significantly; increasing co-insurance, co-payments, or deductibles or out-of-pocket limits by certain amounts; decreasing premium contributions by more than 5%; or, adding or lowering annual limits.[6]

Un-grandfathered plans are group health plans created after the health care law was signed by the President or individual health plans purchased after that date. All un-grandfathered private health plans have to follow the new preventive health services coverage and cost-sharing rules. When you hear that "all new health plans" have to cover these services, it means that all "un-grandfathered" plans must cover them.

Will my plan ever become "un-grandfathered" and have to follow the new rule?
Yes. A recent survey found that 90% of all large U.S. companies expect that their health plans will lose grandfathered status by 2014.[7] Eventually all plans will lose their grandfathered status and distinctions between the two types of plans will disappear. At that point, all plans will cover these important preventive health services without cost sharing.

What about women on Medicaid?
Many states already cover a wide range of preventive services for Medicaid recipients with nominal or no co-pays. While existing Medicaid plans won't be required to cover these services without co-payments, the health care reform law provides a financial incentive for states to do so.[8] The new health care law also expands the group of people who are eligible for Medicaid and requires that this new group of Medicaid enrollees have access to the preventive health services, including the full range of contraceptive coverage, without cost sharing. This means that some women on Medicaid in some states may have access to these benefits, but may not in others.

What about women who are students and enrolled in a student health plan?
The new provisions apply to both group and individual health insurance.[9] Student health plans are considered a type of individual health insurance,[10] and therefore must comply with the preventive health services requirement. In other words, student health plans must offer the preventive health services, including contraceptive coverage, without cost-sharing. The only

[5] *See supra* note 1 at § 1251, 124 Stat. at 161-62.
[6] Preservation of Right to Maintain Existing Coverage, 45 CFR § 147.140 (2011).
[7] Stephen Miller, Society for Human Resources Management, Nine of 10 Big Companies Expect to Lose Grandfathered Status (Aug. 20, 2010), http://www.shrm.org/hrdisciplines/benefits/Articles/Pages/GrandfatherStatus.aspx.
[8] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1406 (2010).
[9] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 45 CFR § 147.130 (2012).
[10] Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets, 45 C.F.R. § 147.145 (2012).

plans excepted from this requirement are self-funded student health plans.[11] Student health plans arranged by non-profit, religious institutions of higher education with religious objections to contraceptive coverage can request an accommodation in the method used to ensure contraceptive coverage for all students.[12]

I've heard about something called the essential health benefits. How are they different from this preventive health services requirement?

Under the new health care law, health plans in the individual and small group markets will be required to provide 10 categories of care, such as maternity and newborn care, and rehabilitative and habilitative care, which the law call "essential health benefits." Because all of these plans will provide these 10 categories of care, consumers can be sure that the plan they use will at least provide this minimum coverage and it will be easier for consumers to compare plans. The Administration has made clear that the preventive services that require coverage without cost sharing are part of the essential health benefits category referred to as "preventive and wellness services and chronic disease management."[13]

I like this part of the new health care law, but I have heard that some people are trying to repeal it. What can I do to keep this important new benefit?

First, you should tell your Member of Congress that you support the new health care law and this new benefit. Next, you should tell your Member of Congress that you support preventive services without co-payments for women. Finally, you should find out where candidates stand on these issues and make sure to vote.

For more information on contraceptive coverage please visit www.nwlc.org/contraceptivecoverage.

[11] While for most university health plans, the student contracts directly with the health insurance company for insurance, a very small number of universities provide self-funded health plans to students. Such self-funded student plans are not considered individual health insurance and are not covered by the preventive services rule.

[12] The preamble to the final rule on student health plans states that if a college or university and its student health insurance plan satisfy the terms necessary to take advantage of the temporary, one-year enforcement safe harbor until Aug. 1, 2013, then they can do so. During the safe harbor period, the Administration will work to develop an alternative way of providing contraceptive coverage to students and dependents in these plans. Student Health Insurance Coverage, 77 Fed. Reg. 16,453 (March 21, 2012) (to be codified at 45 C.F.R. 144). For more information on religious accommodations, please see our fact sheet Contraceptive Coverage "Accommodation" of Religiously-Affiliated Employers: Frequently Asked Questions. http://www.nwlc.org/contraceptivecoverageaccommodation.

[13] Dep't of Health & Human Srvcs., Ctrs. For Medicare & Medicaid Srvcs., Frequently Asked Questions on Essential Health Benefits 5 (Feb. 17, 2012), available at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.