

FACT SHEET

Women's Preventive Services in the Affordable Care Act

December 2013

The 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 go without necessary 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, the 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 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 these services, you will not be charged a co-payment or co-insurance for the services, nor will you need to pay out-of-pocket if you have not yet met your deductible.

What are the Women's Preventive Services that began on August 1, 2012?

As of August 1, 2012, all new health plans must cover a range of women's preventive services without cost sharing. These services have been identified by the Institute of Medicine and endorsed by the Health Resources and Services Administration. They include:

- (1) Breastfeeding support, supplies, and counseling;
- (2) Screening and counseling for interpersonal and domestic violence;
- (3) Screening for gestational diabetes;
- (4) DNA testing for high-risk strains of HPV;
- (5) Counseling regarding sexually transmitted infections, including HIV;
- (6) Screening for HIV;
- (7) Contraceptive methods and counseling;² and
- (8) Well woman visits.³

What other preventive services are also covered under the law?

All new health insurance plans must cover, without cost-sharing, preventive services derived from four sets of expert recommendations: (1) services given an "A" or "B" recommended by the U.S. Preventive Services Task Force; (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) as noted above, 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.⁴

Required services that are of critical importance for women, include:

- (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.⁵

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

Does this mean I won't have to pay anything for preventive services?

You will be able to get the included preventive services with no co-payment. While some plans previously covered preventive services with no cost sharing requirements, many only paid a portion of the cost, while the patient would have to pay a co-payment or co-insurance. Now, the full range of services will be fully covered by insurance plans and you will not need to make a separate payment to your doctor or pharmacy.

Won't this make my monthly premiums go up?

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 cost-saving.

When did these requirements take effect?

All new plans are required to cover these preventive services as of August 1, 2012, or their next new plan year. Qualified Health Plans offered within the Marketplace must cover these services without cost-sharing when they begin on January 1, 2014.

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.⁶ Grandfathered plans don't have to follow the new preventive services coverage 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.⁷

Un-grandfathered plans are group health plans created after March 23, 2010, group health plans that have implemented significant changes, or individual plans purchased after that date, which is when the health care law was signed by the President. 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?

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.

Will women with Medicaid coverage get new preventive benefits?

The health care law expands eligibility for Medicaid coverage 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.⁸ In addition, while states are not required to provide this coverage to individuals who qualify for the traditional Medicaid program, the health care reform law provides a financial incentive for states to do so.⁹

What about women who are students and enrolled in a student health plan?

The new provisions apply to both group and individual health insurance.¹⁰ Student health plans are considered a type of individual health insurance,¹¹ and therefore must generally comply with the preventive health services requirement and cover these services without cost-sharing. However, if you joined your student health plan before enactment of the Affordable Care Act (March 23, 2010) it may still be grandfathered and therefore need not comply with this requirement. Other plans excepted from this requirement are self-funded student health plans.¹²

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

Under the health care law, health plans in the individual and small group markets must cover 10 categories of benefits, such as maternity and newborn care, and rehabilitative and habilitative care, which the law calls “essential health benefits.” 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

- 1 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1001, 124 Stat. 119, 131 (2010) (to be codified at 42 U.S.C. § 300gg-13).
- 2 Some religious employers, such as churches and other houses of worship, are exempt from the contraceptive coverage requirement. In addition, the Department of Health and Human Services has established an accommodation that allows other religious organizations to avoid covering contraception directly, but ensures that the women who work for them still receive contraceptive coverage without cost-sharing.
- 3 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/>.
- 4 Id.
- 5 For a complete list of the USPSTF recommendations, please visit <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>.
- 6 See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1251, 124 Stat. 119, 161-62 (2010) (to be codified at 42 U.S.C. §18011).
- 7 Preservation of Right to Maintain Existing Coverage, 45 CFR § 147.140 (2011).
- 8 The Supreme Court held in its decision on the Affordable Care Act that states need not participate in the expansion of Medicaid as a condition of continuing to receive their current Medicaid funding. Nat'l Fed'n of Indep. Bus. et al. v. Sebelius, 567 U.S. ___ (2012).
- 9 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1406 (2010).
- 10 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).
- 11 Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets, 45 C.F.R. § 147.145 (2012).
- 12 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.
- 13 Dep't of Health & Human Svcs., Ctrs. For Medicare & Medicaid Svcs., 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>.