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Health Reform Update: Women's Health Preventive Care Requirements

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Earlier this week, the Department of Health and Human Services (HHS) issued detailed guidelines regarding women's health care services that group health plans and health insurance policies must cover without cost-sharing pursuant to Section 2713 of the Patient Protection and Affordable Care Act, as amended (ACA). These guidelines amend and supplement the interim final rules relating to coverage of preventive services that were issued on July 19, 2010 (the Preventive Care Interim Final Rules). Proskauer's Client Alert on the Preventive Care Interim Final Rules can be found here: [dated July 22, 2010].

The guidelines mandate that group health plans and health insurance policies cover the following women's health care services without requiring a co-payment, co-insurance or deductible:

Type of Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
Well-woman visits.	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines, as well as others referenced in section 2713.	Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.
Screening for gestational diabetes.	Screening for gestational diabetes.	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Human papillomavirus testing.	High-risk human papillomavirus DNA testing in women with normal cytology results.	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Counseling for sexually transmitted infections.	Counseling on sexually transmitted infections for all sexually active women.	Annual.
Counseling and screening for human immune-deficiency virus.	Counseling and screening for human immune-deficiency virus infection for all sexually active women.	Annual.
Contraceptive methods and counseling.	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.	As prescribed.
Breastfeeding support, supplies, and counseling.	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth.
Screening and counseling for interpersonal and domestic violence.	Screening and counseling for interpersonal and domestic violence.	Annual.

The guidelines apply to the first plan year that begins on or after August 1, 2012, which means that for calendar year plans the guidelines will be effective beginning January 1, 2013. The release and effective date were specifically intended to ensure that plans covering college students, which commonly begin new policy years in August, are subject to the guidelines for the 2012-2013 plan year.

In connection with the release of the guidelines, the Department of Treasury, the Department of Labor and HHS jointly issued an additional amendment to the Preventive Care Interim Final Rules that allows HHS to establish an exemption from the requirement to provide contraception for religious employers. A definition of "religious employer" that is based on the existing definition used by most States that require coverage of contraceptives, but exempt religious employers from this requirement, is also included in the amendment.

[1] This likely should have been 9.5 percent, which is the level at which an individual generally becomes eligible for federal premium assistance instead of a free choice voucher.