



## Health care reform at-a-glance

# Women's preventive care enhancements

The Affordable Care Act (ACA or health care reform law) requires nongrandfathered health plans to cover evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) department of HHS.

In [guidelines released August 1, 2011](#), HHS outlined required preventive care services for women. The guidelines require nongrandfathered individual and group health plans to include these services without cost sharing:

- Well-woman visits
- Screening for gestational diabetes
- Testing for human papillomavirus (HPV)
- Counseling for sexually transmitted infections
- Screening and counseling for human immunodeficiency virus (HIV)
- FDA-approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies and counseling
- Screening and counseling for interpersonal and domestic violence

For group health plans (whether insured or ASO), these services must be provided at the first plan year on or after August 1, 2012. For individual plans, the services must be provided in new policies beginning on or after August 1, 2012, and existing policies beginning at the start of the next policy year following August 1, 2012 (generally January 1, 2013). System and market considerations may accelerate the effective date in the individual market in some states.

The guidelines require coverage of contraceptive methods "as prescribed." This language appears to limit the coverage requirement to contraceptive methods that require a prescription; future guidance may clarify this issue. The guidelines allow plans to encourage lower-cost contraceptives by charging cost-sharing for brand-name contraceptives when a generic is available.

The initial guidance about these requirements allowed a narrowly defined group of religious employers (essentially just churches) to choose not to cover contraceptives and sterilizations as part of preventive care benefits. Many other religious groups, such as religiously affiliated hospitals and universities, will not qualify for this exemption. On February 10, 2012, the administration announced its intention to issue revised regulations. According to a [White House Fact Sheet](#), the revised regulations will:

- Exempt churches, other houses of worship and similar organizations from covering contraception on the basis of their religious objections.
- Establish a one-year transition period for other religiously affiliated organizations while this policy is being implemented.

See the "questions and answers" section for more details about options for religious and religiously affiliated employers. We will provide updates as more information becomes available.

**For plan years/renewals on or after August 1, 2012, plans that have health care reform-compliant preventive benefits will include expanded coverage for women's preventive care. If there is any rate change as a result of these services being added to your plan, it will be reflected in your renewal.**



## Summary of the changes

Benefit changes are outlined in the following table. We will make these benefit changes on plans that have health care reform-compliant preventive care benefits. This includes:

- Nongrandfathered group and Individual plans that need to follow the law's preventive care rules.
- Grandfathered group plans that were modified to include the initial set of ACA-compliant preventive care requirements. NOTE: Some of these plans may have cost share on preventive.
- Grandfathered Individual plans that were modified to include the initial set of ACA-compliant preventive care requirements.

Requirement	How we will cover these services when the changes take effect
Well woman preventive care visits for women to obtain the recommended preventive services that are age and developmentally appropriate	Since we already cover preventive visits within our preventive care benefit, no additional services will have to be covered. To ensure women are able to obtain all of the preventive services as recommended, we will cover preventive visits without applying any annual limits.
Screening for gestational diabetes	We will add these services to the preventive benefit.
High-risk human papillomavirus (HPV) testing in women	We will add these services to the preventive benefit.
Counseling for sexually transmitted infections (STIs) for all women	No changes. We are already covering these services within our preventive care benefit.
HIV counseling and testing for all women	No changes. We are already covering these services within our preventive care benefit.
<p><b>Contraceptives and counseling</b> — all Food and Drug Administration approved contraceptive methods (as prescribed), sterilization procedures, and patient education and counseling for all women</p> <p><i>The law provides two options for different kinds of religious organizations to exclude contraceptive coverage from their plan. See the "questions and answers" section for details.</i></p>	<p>No new coverage is needed for the educational and counseling requirement since we are already covering these services within our preventive care benefit.</p> <p>We will add coverage for medical contraceptives and sterilizations (office- and facility- based medical and surgical services) to the preventive benefit. Only services for females will be covered as part of the preventive benefit.</p> <p>We will add coverage for pharmacy prescription contraceptives for females to the preventive benefit. Coverage will be available through retail or mail. For prescription contraceptives, cost-share will vary based on the type of drug and the plan's benefit structure:</p> <ul style="list-style-type: none"> <li>• Generic drugs and brand drugs that don't have a generic equivalent (single source brand) will have no cost-share.</li> <li>• Brand drugs that have a generic equivalent (multi-source brand) under a Preferred Generic benefit will require the member to pay the difference between the brand drug and generic drug, consistent with the treatment of other multi-source brands.</li> </ul>

Requirement	How we will cover these services when the changes take effect
	<ul style="list-style-type: none"> <li>• Brand drugs that have a generic equivalent (multi-source brand) and don't have a Preferred Generic benefit will have no cost-share.</li> </ul> <p>We will not cover over-the-counter contraceptives.</p>
<b>Breastfeeding support, supplies and counseling — includes</b> comprehensive lactation support and counseling and costs for renting breastfeeding equipment	<p>No new coverage is needed for the lactation support and counseling requirement since we are already covering these services within our preventive care benefit.</p> <p>We will add coverage for breast pumps (rental and purchase) and breast pump supplies to the preventive benefit.</p> <ul style="list-style-type: none"> <li>• This will be a medical (not pharmacy) benefit.</li> <li>• We will limit coverage to one breast pump per year.</li> <li>• Breast pumps must be obtained from a network provider to ensure coverage with no member cost share.</li> </ul>
<b>Screening for interpersonal and domestic violence</b>	<p>No changes. We are already covering these services within our preventive care benefit.</p>

## Questions and answers

### Q. Under what circumstances can a religious organization exclude contraceptive coverage?

A. The law provides two options for religious organizations to exclude contraceptive coverage from their plan. We will allow religious exemptions, but there are very specific guidelines for when those are permitted. These options will be available to all size groups, fully insured or ASO, as long as they meet the specific definition or criteria defined by the government.

1. **Religious group exemption** — Permits religious groups to exclude coverage for contraceptives. For this purpose, the definition of religious groups are nonprofits that
  - have the purpose of cultivating religious values,
  - employ mainly people of similar religious beliefs, and
  - serve people with similar religious beliefs.

Groups will be required to sign and provide to HHS upon request a certification document stating they meet the definition as set forth in the requirement. When an exemption is requested, we will require this certification document be provided to us on an annual basis.

2. **Enforcement safe harbor** — This temporary waiver is available to nonprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plan (their plan coverage in effect on February 10, 2012). These groups will be provided an additional year (until August 1, 2013) to begin to comply with the new contraceptive coverage requirements. Groups will have to add the contraceptive coverage at their next renewal on or after August 1, 2013, unless HHS modifies the rule before then.



Groups will be required to sign and provide to HHS upon request a certification document stating they meet the definition as set forth in the requirement. When an enforcement safe harbor is requested, we will require this certification document be provided to us.

If, at the end of the safe harbor period (no earlier than August 1, 2013), the group still does not want to implement contraceptive coverage, another option may be available. This option would permit them to opt out of covering contraceptives while still ensuring any women covered under their plan are provided access to contraceptive coverage. We will provide more information as the administration works through the details of this new option. Since this option would take effect no earlier than August 2, 2013, we have time to evaluate the impact on our customers and our operations.

***The default for renewals will be for all nongrandfathered groups to receive contraceptive coverage. Groups will need to request and certify they qualify for the exemption or the waiver.***

**Q. How much will rates change because of the new women's preventive requirements?**

A. The specific cost impact will vary depending on the plan's current benefit design and utilization. For both group and Individual plans, any rate change will be reflected in the renewal for the upcoming plan year.

**Q. Will facility charges for a sterilization procedure done at the same time as a maternity stay be covered at 100%?**

A. We will cover the facility charges at 100% only if the primary purpose of the facility stay was for the sterilization procedure. If the primary purpose of the facility stay was for a maternity delivery (or other medical reason), the facility stay will not be covered as preventive but will be covered as maternity or medical, with the appropriate cost-share applied.

**Q. Will sterilizations for men be covered as preventive?**

A. No, the guidelines apply to women only. Sterilization procedures for men will be covered under the surgical benefit, with the applicable cost-share applied.

**Q. Will sterilization reversals be covered as preventive?**

A. No. This is not a contraceptive procedure.

**Q. Where can a woman get a breast pump?**

A. To receive the full 100% coverage, the breast pump must be received from a [DME supplier](#) in the DME network that supplies breast pumps, or from a professional provider or facility in their network. If a breast pump is purchased from a different source, the DME out-of-network benefit may apply (if available), including the applicable cost share.

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