



Newsroom

Affordable Care Act Rules on Expanding Access to Preventive Services for Women

Before health reform, too many Americans didn't get the preventive health care they need to stay healthy, avoid or delay the onset of disease, lead productive lives, and reduce health care costs. Often because of cost, Americans used preventive services at about half the recommended rate.

Yet chronic diseases – which are responsible for 7 of 10 deaths among Americans each year and account for 75% of the nation's health spending – often are preventable. Cost sharing (including copayments, co-insurance, and deductibles) reduces the likelihood that preventive services will be used. Especially concerning for women are studies showing that even moderate copays for preventive services such as mammograms or pap smears deter patients from receiving services.

The Affordable Care Act – the health insurance reform legislation passed by Congress and signed into law by President Obama on March 23, 2010 – helps make prevention affordable and accessible for all Americans by requiring health plans to cover recommended preventive services without cost sharing.

Under the Affordable Care Act, women's preventive health care services – such as mammograms, screenings for cervical cancer, and other services – are already covered with no cost sharing for new health plans. The Affordable Care Act also made recommended preventive services free for people on Medicare. However, the law recognizes and HHS understands the need to take into account the unique health needs of women throughout their lifespan.

On August 1, 2011, the Department of Health and Human Services (HHS) adopted additional Guidelines for Women's Preventive Services – including well-woman visits, support for breastfeeding equipment, contraception, and domestic violence screening – that will be covered without cost sharing in new health plans starting in August 2012. The guidelines were recommended by the independent Institute of Medicine (IOM) and based on scientific evidence.

Under the law, many private plans also must cover regular well-baby and well-child visits without cost sharing. With the addition of these new benefits, the Affordable Care Act continues to make wellness and prevention services affordable and accessible for more and more Americans.

Women and Preventive Health

When it comes to health, women are often the primary decision maker for their families and the trusted source in circles of friends. They are also key consumers of health care. Women have unique needs and have high rates of chronic disease, including diabetes, heart disease, and stroke.

While women are more likely to need preventive health care services, they often have less ability to pay. On average they have lower incomes than men and a greater share of their income is consumed by out-

of-pocket health costs. A report by the Commonwealth Fund found that in 2009 more than half of women delayed or avoided preventive care because of its cost, as compared to one-quarter of women in 2007. Removing cost sharing requirements improves women's access to important preventive services. In fact, one study found that the rate of women getting a mammogram went up as much as 9% when cost sharing was removed.

New Comprehensive Coverage for Women's Preventive Care

The Affordable Care Act helps make prevention affordable and accessible for all Americans by requiring new health plans to cover and eliminate cost sharing for preventive services recommended by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the Bright Futures Guidelines recommended by the Academy of Pediatrics.

The law also requires insurance companies to cover additional preventive health benefits for women. For the first time, HHS is adopting new guidelines for women's preventive services to fill the gaps in current preventive services guidelines for women's health, ensuring a comprehensive set of preventive services for women.

Previously, preventive services for women had been recommended one-by-one or as part of guidelines targeted at men as well. The Department of Health and Human Services directed the Institute of Medicine (IOM), for the first time ever, to conduct a scientific review and provide recommendations on specific preventive measures that meet women's unique health needs and help keep them healthy. HHS used the IOM report issued July 19, 2011 when developing the guidelines being issued today.

Additional women's preventive services that will be covered without cost sharing requirements include:

- **Well-woman visits:** This would include an annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their providers determine they are necessary. These visits will help women and their doctors determine what preventive services are appropriate, and set up a plan to help women get the care they need to be healthy.
- **Gestational diabetes screening:** This screening is for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes. It will help improve the health of mothers and babies because women who have gestational diabetes have an increased risk of developing type 2 diabetes in the future. In addition, the children of women with gestational diabetes are at significantly increased risk of being overweight and insulin-resistant throughout childhood.
- **HPV DNA testing:** Women who are 30 or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of pap smear results. Early screening, detection, and treatment have been shown to help reduce the prevalence of cervical cancer.
- **STI counseling, and HIV screening and counseling:** Sexually-active women will have access to annual counseling on HIV and sexually transmitted infections (STIs). These sessions have been shown to reduce risky behavior in patients, yet only 28% of women aged 18 to 44 years reported that they had discussed STIs with a doctor or nurse. In addition, women are at increased risk of contracting HIV/AIDS. From 1999 to 2003, the CDC reported a 15% increase in AIDS cases among women, and a 1% increase among men.
- **Contraception and contraceptive counseling:** Women will have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. These recommendations do not include abortifacient drugs. Most workers in employer-sponsored plans are currently covered for contraceptives. Family planning services are an essential preventive service for women and critical to appropriately spacing and ensuring

intended pregnancies, which results in improved maternal health and better birth outcomes.

- **Breastfeeding support, supplies, and counseling:** Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment. Breastfeeding is one of the most effective preventive measures mothers can take to protect their children's and their own health. One of the barriers for breastfeeding is the cost of purchasing or renting breast pumps and nursing related supplies.
- **Domestic violence screening:** Screening and counseling for interpersonal and domestic violence should be provided for all women. An estimated 25% of women in the U.S. report being targets of intimate partner violence during their lifetimes. Screening is effective in the early detection and effectiveness of interventions to increase the safety of abused women.

The coverage of these preventive services gives Americans access to many of the services already offered to Members of Congress. In addition, not only are these services similar to a list of preventive services recommended by the National Business Group on Health, but many private employers already cover these services.

New private health plans must cover the guidelines on women's preventive services with no cost sharing in plan years starting on or after August 1, 2012.

An interim final rule was released alongside the women's prevention guidelines to give religious organizations the choice of buying or sponsoring group health insurance that does not cover contraception if that is inconsistent with their tenets. This proposal is modeled on the most common exemption available in the 28 states that already require insurance companies to cover contraception. We invite the public to comment on this proposal as we work to strike the balance between providing access to proven prevention and respecting religious beliefs. In the event that this exemption is modified, it would remain effective on August 1, 2012.

In addition, the rules governing coverage of preventive services which allow plans to use reasonable medical management to help define the nature of the covered service apply to women's preventive services. Plans will retain the flexibility to control costs and promote efficient delivery of care by, for example, continuing to charge cost sharing for branded drugs if a generic version is available and just as effective and safe.

These Guidelines Mean Fewer Health Disparities

Not all Americans have equal access to health care. Low-income and racial and ethnic minorities often have higher rates of disease, fewer treatment options, and reduced access to care. By eliminating cost sharing requirements, these guidelines help improve access to comprehensive quality health care for all women.

You can read the Guidelines for Women's Preventive Services at: www.hrsa.gov/womensguidelines/

Read the interim final rule at http://www.ofr.gov/OFRUpload/OFRData/2011-19684_PI.pdf.

Posted on: August 1, 2011