New Affordable Care Act Insurance Regulations Improve Reproductive Health & Access

November 2010

Introduction

The Patient Protection and Affordable Care Act (ACA), as amended by the Health Care and Education Reconciliation Act\(^1\), expands access to reproductive health care and related services for many individuals. The health care reform law, signed in March of 2010, is being implemented in phases over the next few years, concluding in 2014. On September 23, 2010, six months after reform was passed, a number of provisions that regulate insurance coverage went into effect. As a result, these regulations generally apply to health plans with plan years beginning after September 23, 2010. However, health plans that have “grandfathered” status are exempt from some of the regulations. A “grandfathered” health plan is one that existed when the ACA was signed on March 23, 2010. Health plans maintain their exempt, “grandfathered” status going forward unless the insurer significantly increases costs or reduces benefits to consumers.\(^2\)

Since the law’s signing, federal agencies have been issuing guidelines in order to implement the various provisions. The discussion below describes how the ACA and federal guidelines will strengthen the rights of individuals with private insurance and how these changes will affect reproductive health care.

Direct access to obstetricians and gynecologists

Going forward, the law requires that women with new health plans (plan years beginning after September 23, 2010) have direct access to an obstetrician or gynecologist (OB/GYNs).\(^3\) This provision does not apply to the “grandfathered” health plans that were in place before March 23, 2010.\(^4\) Under the law, insurers can still require women to visit an available, in-network OB/GYN, they can no longer require women to obtain a referral from a primary care provider before making an appointment.\(^5\) In addition, women will not need to obtain authorization from their primary care provider for the care and ordering of obstetric and gynecologic services by their participating OB/GYN.\(^6\) This provision, which was strongly advocated by the American Congress of Obstetricians and Gynecologists\(^7\), gives women in covered plans easier access to OB/GYNs where they can receive services such as pelvic and breast exams without the extra time and expense of needing permission from their primary care providers.

Certain preventive health services must be provided without cost sharing

New health plans (plan years beginning after September 23, 2010) are required to cover certain recommended preventive health services without cost sharing (i.e., no co-payments or deductibles).\(^8\) For individuals with a provider network (e.g., HMO plans), this requirement only applies to in-network services; insurers may still charge a fee for out-of-network services.\(^9\) “Grandfathered” plans that were in place before March 23, 2010, and have not made major changes do not have to follow this requirement.\(^10\) Guidelines for designated preventive services fall under four categories, all of which impact reproductive health care.

First, insurers must cover evidence-based preventive services graded A or B by the U.S. Preventive Services Task Force, with respect to the individual involved.\(^11\) These preventive services include:

- breast cancer screening every one to two years for women age 40 and older\(^12\);  
- cervical cancer screening\(^13\);  
- screening for sexually-transmitted infections, including HIV\(^14\);  
- interventions to support and promote breast feeding\(^15\); and  
- certain health screenings for pregnant women.\(^17\)

Second, health plans will be required to fully cover costs for a number of vaccines recommended for routine use by the
Advisory Committee on Immunization Practices\textsuperscript{18}, including: Hepatitis A and B; the HPV vaccine (for females); and herpes zoster for individuals 19 and older.\textsuperscript{19}

Third, health plans must fully cover costs for the preventive care and screenings for infants, children and adolescents recommended by the Bright Futures guidelines.\textsuperscript{20} These guidelines, developed by the Health Resources and Services Administration and the American Academy of Pediatrics, include recommendations for adolescent physician visits and suggest screening for sexually-transmitted infections (STIs), pregnancy, and cervical dysplasia, following a risk assessment.\textsuperscript{21}

Finally, the law requires insurers to cover additional, evidence-informed preventive care and screenings for women, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.\textsuperscript{22} The Department of Health and Human Services, in cooperation with the Institute of Medicine,\textsuperscript{23} is currently developing these guidelines and expects to issue them by August 1, 2011.\textsuperscript{24}

Contraception and other family planning services may be included in this list.\textsuperscript{25}

**Insurance companies cannot rescind coverage when people get sick**

Under the new law, insurers cannot cancel, or rescind, coverage when a person becomes sick unless there has been fraud or an intentional misrepresentation of material fact.\textsuperscript{26} In the past, insurance companies identified reasons to rescind or cancel the policies of people who became sick – including individuals with breast cancer or those diagnosed with HIV – as a way to avoid paying for medical treatments.\textsuperscript{27}

Once a rescission occurs, an individual’s health coverage is retroactively cancelled. This means that the insurance company returns the individual’s premium payments and the individual is responsible for all costs – even those already paid by the insurance company.\textsuperscript{28} In addition, it can be difficult for an individual who has experienced a rescission to obtain insurance coverage in the future; some insurance companies will automatically deny applications indicating a prior rescission.\textsuperscript{29}

When implementing the rescission ban, federal regulations pointed to a congressional hearing that revealed questionable practices by insurance companies, including rescinding coverage even when discrepancies are unintentional or caused by others, for conditions that are unknown to policyholders, and for discrepancies unrelated to the medical conditions for which patients sought care.\textsuperscript{30} This new protection against unjust rescission applies to all health plans which begin after September 23, 2010, including “grandfathered” plans.\textsuperscript{31}

By guaranteeing coverage to individuals who might have faced unwarranted rescission, this provision also guarantees that those with new plans will maintain access to coverage without co-pays for the preventive health services discussed above.

**Insurers cannot deny coverage to children with “pre-existing conditions”**

Insurers are prohibited from denying coverage to children ages 0-19 with “pre-existing conditions” such as asthma and diabetes.\textsuperscript{32} This regulation applies to both individual health plans and job-related group plans with plan years beginning after September 23, 2010.\textsuperscript{33} However, “grandfathered” individual health plans can refuse to cover a child.\textsuperscript{34} With this new regulation, children with new health plans who might have been denied coverage will now have access to coverage without co-pays for the preventive health services discussed above.

In 2014, insurers will also be prohibited from denying coverage to adults with pre-existing conditions.\textsuperscript{35} This means, for example, that individual health plans will no longer be able to deny coverage to women who are pregnant or have previously given birth by cesarean delivery.\textsuperscript{36}

**Insurance coverage is extended for young adults up to age 26**

The law requires all health plans that offer dependent coverage to permit young adults to remain on their parents’ health insurance policy until age 26.\textsuperscript{37} This law applies to all plans with plan years beginning after September 23, 2010, including “grandfathered” plans. A small transitional exception exists until 2014; if the young adult has an insurance offer from his or her own employer, the parent’s insurer is not required to extend coverage.\textsuperscript{38} Previously, most plans ended coverage for children when they turned 19 or graduated from college. With the new law, insurers cannot condition coverage on whether a child is a student, a tax dependent, unmarried, or lives with or receives support from the parent.\textsuperscript{39} Furthermore, if a child remains on a parent’s policy, he or she cannot be charged more than any other dependent. By also ensuring coverage for children with pre-existing conditions, the law opens the door for those youth to maintain coverage through a parent’s plan up to age 26. However, the insurer is not required to cover the child of an adult dependent child (i.e., the grandchild of an insurance policy holder).\textsuperscript{40}

The Departments of Health and Human Services, Labor, and Treasury estimated that, in 2010, there would be about 6.6 million uninsured young adults between the ages of 19 and 26.\textsuperscript{41} About 3.3 million of uninsured young adults and about 2 million of those with individual plans have parents with
employer-based health insurance and so could be eligible for dependent coverage up to age 26 under the new law. With the extension of dependent coverage, more young adults will have access to insurance coverage for reproductive health care; youth whose parents have new plans will have access to preventive reproductive health services without co-pays.

**New insurance plans must develop an appeals process for coverage determinations**

In the past, it was difficult to challenge the determinations made by insurance companies regarding coverage of a particular claim. Now insurers must implement an effective appeals process which protects consumer rights and includes:

- Notice to the enrollee of the process and the availability of any office of health insurance consumer assistance to assist with the process;
- The ability of an enrollee to review files, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeal; and
- An external review process including consumer protections established by the National Association of Insurance Commissioners.\(^43\)

**No lifetime limits; annual limits restricted**

All health plans with plan years beginning after September 23, 2010, including “grandfathered” plans, will be prohibited from setting dollar limits on lifetime coverage. In addition, regulation of annual limits has begun; annual limits on costs for “essential health benefits” will eventually be phased out by 2014. Annual and lifetime limits function as caps on spending for medical care; once a person reaches the limit or cap, the person must pay the remaining cost of medical care out-of-pocket. These limits particularly affect people with serious, high-cost conditions. For example, the lifetime treatment costs for HIV positive individuals can reach an estimated $618,000. In addition, one recent survey found that 10 percent of cancer patients reached the limit of what insurance would pay for treatment.\(^48\)

**Looking forward**

The ACA has begun to increase access to a number of reproductive health care services. Additional provisions going into effect by 2014 can further enhance access. Insurance companies will be prohibited from pricing health plans based on gender, ending a practice where women in their twenties can be charged 50 percent more than men for identical health plans. New state health insurance exchanges will be created where individuals can compare and purchase health plans. At a minimum, plans in the exchange will contain government-defined “essential health benefits”, which will include maternity care.\(^50\) Individuals with low and moderate incomes will be able to apply for subsidies to purchase these plans. Furthermore, Medicaid eligibility will be expanded to cover adults with incomes below 133 percent of the federal poverty level. Recent elections may affect implementation going forward; state governments in particular will determine how insurance exchanges are established and operated. While the current provisions of the ACA point toward greater reproductive health access, decisions on implementation and funding going forward will determine the extent of that access.

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immunization schedules developed by the Centers for Disease Control and Prevention. When it was passed, several senators pointed to family planning services as a potential preventive service.

A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention. The USPSTF recommends: screening for chlamydia in all sexually active women aged 24 and younger and for older pregnant women at increased risk; screening for hepatitis B in pregnant women at their first prenatal visit; Rh (D) blood typing and antibody testing during first prenatal visit; repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks’ gestation, unless the biological father is known to be Rh (D)-negative; screening all pregnant women for syphilis.

The USPSTF recommends: screening for chlamydia in all pregnant women aged 24 and younger for older pregnant women at increased risk; screening for hepatitis B in pregnant women at their first prenatal visit; Rh (D) blood typing and antibody testing during first prenatal visit; repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks’ gestation, unless the biological father is known to be Rh (D)-negative; screening all pregnant women for syphilis.

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38 Id.

39 Id.

40 Id.

41 Id. See also S.R. Collins and J.L. Nicholson, *Rite of Passage: Young Adults and the Affordable Care Act of 2010*, The Commonwealth Fund, May 2010.


45 Id. at 37,191.

46 Id. Regulations specifically defining “essential health benefits” have not yet been issued, but Section 1302(b) of the Affordable Care Act indicates the term will include: emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative services; laboratory services; preventive and wellness services and chronic disease management; and pediatric services.” Id.


