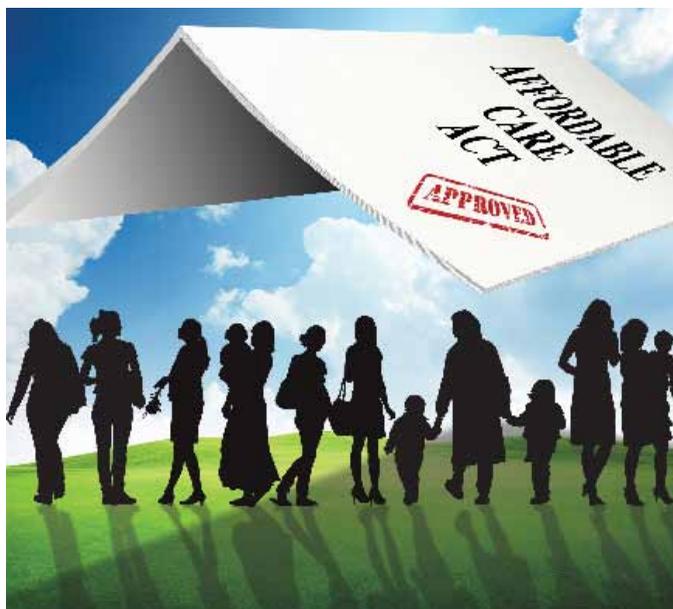


# Women's health under the Affordable Care Act: What is covered?

↘ Women stand to make considerable gains under health reform, starting with guaranteed access to preventive services without cost-sharing

Lucia DiVenere, MA



muster in *National Federation of Independent Business v. Sebelius* (2012).

Now that the Court has upheld the ACA, let's review the major women's health services included under the law. This Web version incorporates 10 more women's health provisions from the ACA, from smoking cessation to young women's breast cancer, that were not in the print version; see pages 54e–56e.

## Preventive services guaranteed without copays

A major component of the health reform law went into effect August 1, 2012; it requires most health plans to cover women's preventive services without requiring enrollees to pay a copay or deductibles. This provision reflects Congress' understanding that women have a longer life expectancy and bear a greater burden of chronic disease, disability, and reproductive and gender-specific conditions. In addition, women often have a different response to treatment than men do.

The federal Department of Health and Human Services (HHS) estimates that Americans use preventive services at only about half of the recommended rate. By 2013, as many as 73 million individuals will benefit from preventive care offered under the law.

The American Congress of Obstetricians and Gynecologists (ACOG) worked with the Institute of Medicine (IOM)—which was charged with advising HHS—to encourage the inclusion of women's preventive services specified in ACOG guidelines to ensure

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For the first half of 2012, the big question was: Will *anything* be covered under the Affordable Care Act (ACA)?

After considering constitutional challenges to the Act that had the potential to invalidate the entire law, the US Supreme Court ruled, on June 28, that the ACA met constitutional



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ILLUSTRATION: MARY ELLEN NIATAS FOR OBG MANAGEMENT

women's health and well-being. As ACOG Executive Vice President Hal C. Lawrence, MD, told the IOM in January 2011:

The College's clinical guidelines... offer an excellent resource...and encompass the entire field of women's preventive care. Our guidance is based on the best available evidence and is developed by committees with expertise reflecting the breadth of women's health care and subject to a rigorous conflict of interest policy.

Dr. Lawrence further urged the IOM "to recommend coverage of the following services and products *without* cost-sharing":

- well-woman visits
- preconception care
- family planning counseling and services
- HIV screening (for women at average risk)
- screening for intimate partner violence
- testing for human papillomavirus (HPV) as part of cervical cancer screening.

ACOG's recommendations were approved by the IOM and, subsequently, by HHS. As a result, all private health plans that began on or after September 30, 2010, are required to cover these services at no out-of-pocket cost to patients (TABLE, page 48).

### Contraceptive mandate triggers a firestorm

On February 10, 2012, under pressure from religious groups, the Obama Administration offered a religious exemption to the contraception mandate for certain employers and group health plans. Under this "accommodation," certain religious employers are exempt from the requirement to cover contraceptive services in their group health plans. An employer qualifies for this exemption if it:

- has the inculcation of religious values as one of its purposes
- primarily employs individuals who share its religious tenets
- primarily serves individuals who share its religious tenets, and
- qualifies for nonprofit status under

Internal Revenue Service (IRS) rules.

At the same time that the Obama Administration wanted to accommodate employers' religious beliefs, it also wanted to ensure that every woman would have access to free preventive care, including contraceptive services, regardless of where she works. And so while the Administration requires insurers to offer group health plan coverage without contraceptive coverage to religious-affiliated organizations, it also requires insurers to provide contraceptive coverage directly to individuals covered under the organization's group health plan with no cost sharing.

This contraceptive mandate—even with the accommodation—has set off a firestorm on Capitol Hill that will eventually be settled in the courts.

### Medicaid expansion falls short of original goal

In *National Federation of Independent Business v. Sebelius*, the plaintiffs asked the Supreme Court to rule on the federal government's authority to require states to expand their Medicaid programs. Medicaid costs are typically shared by the federal and state governments. Under the ACA, state Medicaid programs were required to cover nearly all individuals who have incomes below 133% of the federal poverty level—\$30,656 for a family of four in 2012—paid entirely by the federal government from 2014 through 2016. After that, the federal share gradually declines to, and then stays at, 90%. States that did not expand their Medicaid programs risked losing all federal Medicaid funding.

The Court ruled that the federal government can expand Medicaid but can't penalize states that don't accept the expansion mandate—effectively turning the mandate into a state option. States will receive the additional federal funds if they expand coverage, but states that don't expand will not be penalized by losing existing federal funds for other parts of the program.

Since the ruling, a number of governors have announced that they will not expand



**All private health plans that began on or after September 30, 2010, are required to cover women's preventive services without cost-sharing**

### NEXT MONTH

Read "Gynecologic care across a woman's life" by Dr. Robert L. Barbieri

**Women's preventive services guaranteed under ACA\***

Service	Frequency	HHS guidelines for health insurance coverage
Well-woman visit	Annual for adult women, 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**	The visit should focus on preventive services that are appropriate for the patient's age and development, including preconception and prenatal care. This visit should, where appropriate, include other preventive services listed in this set of guidelines, as well as others referenced in section 2713
Screening for gestational diabetes	Between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes	
Testing for human papillomavirus (HPV)	At age 30 and older, no more frequently than every 3 years	High-risk HPV DNA testing in women who have normal cervical cytology
Counseling about sexually transmitted infection (STI)	Annual	All sexually active women
Counseling about and screening for HIV	Annual	All sexually active women
Counseling about and provision of contraception†	As prescribed	All FDA-approved contraceptive methods and sterilization procedures. Counseling for all women with reproductive capacity
Breastfeeding support, supplies, and counseling	In conjunction with each birth	Comprehensive lactation support and counseling by a trained provider during pregnancy or postpartum (or both), as well as costs for renting breastfeeding equipment
Screening for and counseling about interpersonal and domestic violence	Annual	

HHS = Health and Human Services

\* HHS guidelines are effective August 1, 2011. Nongrandfathered plans and insurers are required to provide coverage without cost-sharing consistent with HHS guidelines in the first plan year (in the individual market, policy year) that begins on or after August 1, 2012.

\*\* The July 2011 Institute of Medicine report titled "Clinical preventive services for women: closing the gap" lists recommendations on individual preventive services that may be obtained during a well-woman preventive service visit.

† Group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to cover contraceptive services.

SOURCE: Adapted from Healthcare.gov. Affordable Care Act Expands Prevention Coverage for Women's Health and Well-Being. <http://www.healthcare.gov/law/resources/regulations/womensprevention.html>. Accessed August 8, 2012.

their Medicaid programs, including governors of Florida and Louisiana. Those two states alone are home to 20% of all individuals intended to be covered under the Medicaid expansion.

This part of the ACA is particularly important to women because it strikes, for the first time, the requirement that a low-income woman must be pregnant to receive Medicaid coverage.

The **FIGURE** shows the dramatic potential improvement in coverage for women if all states fully implement the Medicaid expansion. Time, court decisions, elections, and

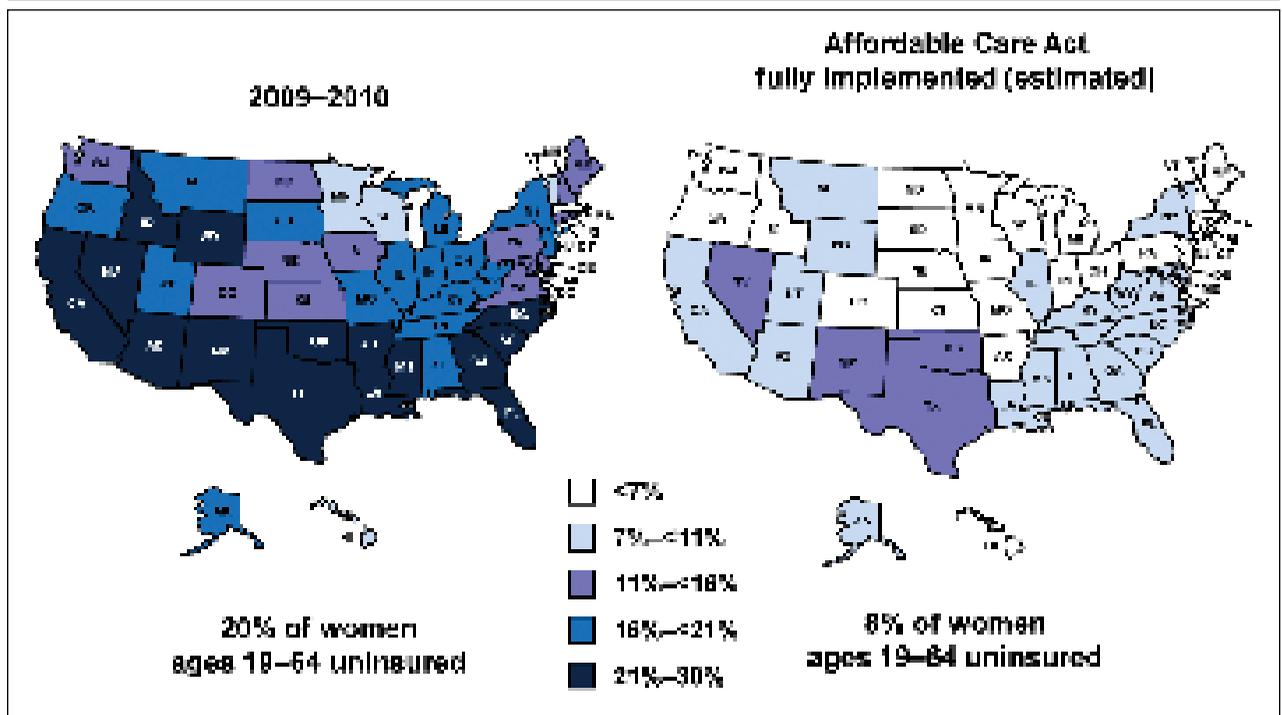
state budget fights will determine how much of this change is realized for women's health.

**Women gain direct access to ObGyns**

The ACA guarantees women in all states and all plans direct access to their ObGyns. Before the ACA, women in nine states lacked this guarantee, and women in 16 other states had only limited direct access. Now, a woman can go directly to her ObGyn without having to get a referral from her primary care physician or insurer.

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## Percentage of insured women will increase under ACA



Percentage of women aged 19 to 64 years who were uninsured in 2009–2012 and under the Affordable Care Act when fully implemented.

SOURCE: Commonwealth Fund. Analysis of the March 2011 and 2010 Current Population Surveys by N. Tilipman and B. Sampat of Columbia University.

Direct access is especially important because the ACA establishes new delivery systems, such as medical homes and accountable care organizations, designed to capture patients to maximize savings. An ObGyn does not have to be the patient's primary care provider, and the patient's access to her ObGyn cannot be limited to a certain number of visits or types of services.

### ACA encourages states to cover family-planning services

Under the ACA, states have an easier time covering family-planning services, up to the same eligibility levels as pregnant women. Family planning is still an optional service that a state can choose to extend to women who have incomes above the Medicaid income eligibility level but, before the ACA was enacted, states had to apply to HHS for permission to waive the federal

rules, often a very cumbersome process.

Prior to the ACA, 27 states had family planning waivers to provide services to non-pregnant women who had incomes above the Medicaid eligibility level—most at or near 200% of poverty. Now, states can provide family planning services to this population without federal approval.

### Insurance reforms end lifetime limits on coverage

Insurance reforms are important to us and our patients. The better the private health insurance system works—allowing us to provide our best possible care to patients and making sure they can see us when they need our care—the less our nation relies on the public safety net.

Beginning in 2010, the ACA eliminated all lifetime limits on how much insurance

## Many physicians report frustration with Medicaid—or avoid it entirely

A recent study reveals that almost one-third of physicians are no longer accepting Medicaid patients

If all states expanded Medicaid to cover people with incomes at or below 138% of the federal poverty level in 2014, as the Affordable Care Act (ACA) proposes, 23 million people would become eligible for the program.<sup>1</sup>

That statistic prompts important questions:

- Would the health-care workforce be able to meet the demand of caring for all these new patients?
- Would it be willing?

A recent analysis of data from 4,326 office-based physicians suggests that the answer to both questions is “No”: Almost one-third of these providers were already declining to accept new Medicaid patients in 2011.<sup>2</sup>

Although 96% of physicians in the analysis accepted new patients in 2011, the percentage of physicians accepting new patients covered by Medicaid was lower (69%), as was the percentage accepting new self-paying patients (91.7%), patients covered by Medicare (83%), and patients with private insurance (82%).<sup>2</sup>

Physicians who were in solo practice were 23.5% less likely to accept new Medicaid patients, compared with those who practiced in an office with 10 or more other physicians.<sup>2</sup>

The data from this study come from the 2011 National Ambulatory Medical Care Sur-

vey Electronic Medical Records Supplement, a survey conducted by the Centers for Disease Control and Prevention National Center for Health Statistics. The survey included questions exploring whether physicians were accepting new patients.<sup>2</sup>

Earlier studies have found that the low reimbursement levels for care delivered through Medicaid has deterred many physicians from accepting patients.<sup>3</sup>

### The view in the ObGyn specialty

The findings of this analysis were not broken down by specialty—only by primary care versus non-primary care. To get an idea of conditions in the ObGyn specialty, OBG MANAGEMENT surveyed the members of its Virtual Board of Editors (VBE). Of the 117 members contacted, 61 responded—a response rate of 52.1%. Roughly three-quarters (75.4%) reported that they currently treat patients covered by Medicaid, but only 60.7% are accepting *new* patients covered by Medicaid. Twenty-one percent of respondents reported that they have not and will not accept patients covered by Medicaid.

When asked to comment on their level of satisfaction with Medicaid, the most common response among VBE members was dissatisfaction due to “insufficient reimbursement.”

companies would cover when beneficiaries get sick; it also bans insurance companies from dropping people from coverage when they get sick. So if your patient has private health insurance and has faithfully paid her premiums and hasn't committed fraud, her insurer cannot drop her or impose a limit on her coverage once she claims benefits.

This may be especially important for patients who need the most care, such as those who have cancer or another long-term, expensive, and unforeseen diagnosis. Because of this provision, you will not have to worry about your patient losing coverage in the middle of a long course of treatment.

The insurance practice of charging women more than men for equivalent policies



Beginning in 2010, the ACA eliminated all lifetime limits on how much insurance companies would cover when beneficiaries get sick

"I am not satisfied with Medicaid," commented one VBE member. "The reimbursement is terrible....I have certainly thought of stopping care for Medicaid patients and, if Congress ever allows the big cuts to reimbursement that are threatened every year, I think I would stop."

Another VBE member reported extreme dissatisfaction with Medicaid because of "lousy" reimbursement. He also pointed to "all the paperwork and crazy regulations that require inordinate time and additional personnel just to handle....and then [the claim] gets denied for reasons beyond reason." He added that physicians who do accept Medicaid "are on the fast track to sainthood."

Other reasons for refusing to accept patients with Medicaid (or, if Medicaid was accepted, for high levels of aggravation with the program):

- payment rejections
- too many different categories of coverage "that patients are completely uninformed about"
- difficulty finding a specialist who will manage high-risk patients covered by Medicaid
- red tape
- the complex health problems that Medicaid patients tend to have, compared with patients who have other types of coverage.

One VBE member summed up his feelings in one word: "Phooey."

Several VBE members suggested that health reform should focus on the Medicaid program.

"These plans are just sucking up the state's money and paying docs peanuts and their administrators big bucks!" wrote Mary Vanko, MD, of Munster, Indiana.

"I'm tired of how much Medicaid is being abused by people," commented another VBE member. "People using other people's cards, people with regular insurance getting Medicaid to cover their copays. The whole system needs reform!"

### Some physicians were satisfied with Medicaid

Among the respondents were several who reported being satisfied with the program, including one who called the experience "good" and another who reported being "shielded from the reimbursement issues."

"I have no problems with Medicaid," wrote another.

—JANELLE YATES, SENIOR EDITOR

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**In 2014, under the ACA, state health insurance exchanges become reality**

ended on January 1, 2011, making insurance more affordable for our patients. Insurers in the individual and small group markets are allowed to vary premiums only for age, geographic location, family size, and tobacco use, not for gender—another important aspect of the law.

### 2014 is a key year in health reform Exchanges begin

In 2014, under the ACA, state health insurance exchanges become reality.

An exchange is a marketplace where people can shop for health insurance; private health insurers can market their insurance products in state and multistate exchanges

if they comply with new federal insurance reforms established in the ACA and offer the minimum benefits packages established by each state. Exchanges are intended to offer patients a choice of health insurance plans that are affordable, comprehensive, and easy to compare. Low-income individuals will be able to purchase private insurance in the exchanges with the federal premium subsidies or tax credits.

Insurers wanting to market their policies in an exchange may not deny coverage for preexisting conditions, including pregnancy, domestic violence, and previous cesarean delivery. They can't deny coverage on the basis of an individual's medical history, health status, genetic information, or disability. And they can't impose waiting periods longer than 90 days before coverage takes effect, including 9-month waiting periods before maternity coverage.

**Essential benefits are established**

The ACA sets a minimum standard of health-care coverage that must be included in nearly every private insurance policy. The intent is that every person in the United States, regardless of where they live, who employs them, and what their income is, should have access to the same basic care.

Effective January 1, 2014, all insurance plans, except plans that existed before the ACA was enacted on March 23, 2010, must offer an "essential health benefits" (EHB) package, which must include:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services
- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- women's preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care.

Last December, HHS surprised many by

giving states flexibility to design their own EHB packages, as long as the packages included each service on the list.

To choose its EHB package, a state must select a "benchmark" plan from the top-selling plans in four markets: federal and state public employee plans, commercial HMO plans, and small business plans. If a state doesn't select a benchmark plan, the EHB defaults to the largest small-group market plan in the state. Each state must also choose an EHB package for its Medicaid program using the same 10 benefit categories.

State EHB plans must follow ACA requirements on annual and lifetime dollar limits but may impose limits on the scope and duration of coverage.

As for state-mandated benefits, if a state selects an EHB package that does not include a benefit already mandated by the state, the state must fund coverage for that service on its own—a decision HHS has promised to revisit in 2016.

**Abortion decisions reside with the states**

ACA requirements regarding abortion coverage **1)** take effect in 2014 and **2)** apply only to private health insurance plans marketed in the state exchanges that **3)** cover abortions beyond those eligible for Medicaid coverage now, which are those that involve cases of rape or incest or that are necessary to save the life of the mother. Medicaid coverage for these categories of abortion is allowed under the Hyde Amendment.

Each insurer marketing a health plan in an exchange can determine whether or not its plan will cover abortion and, if it does, whether coverage will be limited to or go beyond those allowed under the Hyde Amendment. No federal tax or premium subsidies may be used to pay for abortions beyond those permitted by the Hyde Amendment.

The Secretary of HHS must ensure that at least one plan in each state exchange covers abortion, and that at least one plan either covers no abortions or limits abortions to those allowed under the Hyde Amendment.



**ACOG continues to work toward repeal or repair of the Independent Payment Advisory Board and for passage of medical liability reform**

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Insurers who offer abortion coverage beyond Hyde have to comply with a number of administrative requirements.

Congress was clear that the ultimate decisions about abortion should be made at the state rather than the federal level, and it gave states the ultimate trump card: Any state can pass legislation that prohibits any plan from offering abortion coverage of any kind within that state's exchange. Any state can prohibit insurers offering plans within that state's exchange from including any abortion coverage.

### 10 additional health provisions under the ACA

#### 1. Creation of women's medical homes

The law points the way for creation of medical homes for women in the Medicare and Medicaid programs. The bill establishes an Innovation Center within the Centers for Medicare and Medicaid Services that has broad authority to evaluate, test, and adopt systems that foster patient-centered care, improve quality, and contain costs under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP)—and this includes patient-centered medical homes that address women's unique health needs. ObGyn practices are eligible to participate and to receive additional reimbursement if they do.

#### 2. Smoking-cessation counseling in pregnancy

The framers of the ACA recognized the large negative impact that smoking has on health, especially during pregnancy. Studies suggest that the intervention of a physician—most notably, counseling of the patient to quit smoking—has strong potential to modify this behavior. The new law provides reimbursement for this intervention. There are no copays or deductibles for patients, and smoking-cessation services can include diagnostic, therapeutic, and counseling modalities in addition to prescription of pharmacotherapy.

Before this bill became law, only 24 state

Medicaid programs paid ObGyns or other physicians for smoking-cessation counseling of pregnant patients, and five states provided no coverage at all. Now, all pregnant Medicaid patients can get this counseling, and you'll be paid for this important service.

#### 3. Payments to nonphysician providers in freestanding birth centers

Before the ACA became law, Medicaid was authorized to pay hospitals and other facilities operated by and under the supervision of a physician; no payments were authorized for services of an ambulatory center operated by other health professionals. The ACA authorizes Medicaid payments to state-recognized freestanding birth centers not operated by or under the supervision of a physician. A state that doesn't currently license birth centers must pass legislation and license these centers before the centers can receive these payments.

Medicaid will also reimburse providers who practice in state-recognized freestanding birth centers, as long as the individuals are practicing within their state's scope of practice laws and regulations. Because the type of provider is not specified but instead left up to each state's scope of practice laws and regulations, this provision could allow for separate provider payments for physicians, certified nurse midwives, certified professional midwives, and doulas.

#### 4. Immigrant coverage

Legal immigrants are bound by the individual coverage mandate and must purchase health insurance. These individuals are eligible for income-related premium credits and subsidies for insurance purchased through an exchange. Legal immigrants who are barred from Medicaid during their first 5 years in the United States (by earlier law) are eligible for premium credits only.

Undocumented immigrants are not eligible for Medicaid, premium credits, or subsidies and are barred from purchasing insurance in the exchange, even with their own money.



The ACA provides reimbursement for smoking-cessation counseling during pregnancy, with no copays or deductibles for patients

## 5. Postpartum depression

Health reform will help bring perinatal and postpartum depression out of the shadows by providing federal funds for research, patient education, and clinical treatment. For example, the federal Department of Health and Human Services (HHS) will:

- conduct research into the causes of, and treatments for, postpartum conditions
- create a national public awareness campaign to increase awareness and knowledge of postpartum depression and psychosis
- provide grants to study the benefits of screening for postpartum depression and psychosis
- establish grants to deliver or enhance outpatient, inpatient, and home-based health and support services, including case management and comprehensive treatment services for individuals with, or at risk for, postpartum conditions.

The National Institute of Mental Health is encouraged to conduct a 10-year longitudinal study on the mental health consequences of pregnancy. This study is intended to focus on perinatal depression.

Community health centers will be eligible for grants in 2012 (as they were in 2011) to the tune of \$3 million for inpatient and outpatient counseling and services.

And a federal public awareness campaign will educate the public through radio and television ads.

These endeavors point to the need for ObGyns to familiarize themselves with postpartum depression—if they aren't already well versed in the subject—because patients are likely to become more aware of this issue and look to their ObGyns for answers.

## 6. Maternal home visits

Congress established a new Maternal, Infant, and Early Childhood Home Visiting program to improve maternal and fetal health in underserved areas of our country. This program will provide funds to states, tribes, and territories to develop and implement evidence-based home-visitation models to reduce infant and maternal mortality and its causes by producing improvements in:

- prenatal, maternal, and newborn health
- child health and development
- parenting skills
- school readiness
- juvenile delinquency
- family economic self-sufficiency.

These programs will have to demonstrate effectiveness and improved outcomes. HHS recently requested suggestions on ways of demonstrating the effectiveness of home-visiting program models for pregnant women, expectant fathers, and caregivers of children from birth through entry into kindergarten.

The law appropriates \$350 million to this program in 2012 and \$400 million in both 2013 and 2014.

## 7. Assistance for pregnant students

A new Pregnancy Assistance Fund—\$25 million annually over 10 years (fiscal years 2010–2019)—requires the Secretary of HHS (in collaboration with the Secretary of Education) to establish a state grant program to help pregnant and parenting teens and young women. The aim of this program is to help teens who become pregnant and who choose to bring their pregnancies to term or keep their babies, or both, to stay in school. Grants will go to institutions of higher education, high schools and community service centers, as well as state attorneys general.

Institutions that receive grants must work with providers to meet specific practical needs of pregnant or parenting students:

- housing
- childcare
- parenting education
- postpartum counseling
- assistance in finding and accessing needed services
- referrals for prenatal care and delivery, infant or foster care, or adoption.

Funds to attorneys general will be used to combat domestic violence among pregnant teens.

## 8. Young women's breast cancer

A new program is intended to help educate young women about the importance of breast health and screening, in two ways:



**The ACA appropriated \$350 million for a new Maternal, Infant, and Early Childhood Home Visiting program in 2012**

- The National Institutes of Health (NIH) will conduct research to develop and test screening measures for prevention and early detection of breast cancer in women 15 to 44 years old.
- The US Department of HHS will create a national awareness campaign, with \$9 million in funding each year from 2010 to 2014, to encourage young women to talk with their doctors about breast cancer and early detection.

ObGyns can expect to see more interest and questions about breast health among young women and their mothers. It pays to be prepared with good information for these important conversations.

**9. Personal responsibility education**

From 2010 through 2014, each state will receive funds for personal responsibility education programs aimed at reducing pregnancy in youths. Funds are \$75 million for each fiscal year, allocated to each state depending on the size of its youth population but not intended to be less than \$250,000 per state.

Educational programs eligible for federal funds must include both abstinence and contraception information for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS, as well as three or more adulthood-preparation subjects.

**10. Community-based support of Patient-Centered Medical Homes**

Federal funding is available to states for the development of community-based health teams to support medical homes run by primary care practices. These teams may include specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers, and physician assistants. Primary care practices in this program function as medical homes and are responsible for addressing a patient's personal health-care needs. The team links the medical home to community support services for its patients.

Eligible ObGyn practices can qualify as primary care practices, and ObGyns are eligible to serve as specialist members of the community-based health team.

**ACA is a mixed bag for ObGyns**

Women have much to gain from the provisions of the ACA. It's also true that many parts of the law are terrible for practicing ObGyns, including the Independent Payment Advisory Board (IPAB) and the absence of meaningful medical liability reform. For more on these issues, see "Is private ObGyn practice on its way out?" which appears in the October 2011 issue of OBG MANAGEMENT (available in the archive at obgmanagement.com). ACOG is committed to working with Congress to repeal or remedy those aspects of the law. 📧



**ACOG continues to work toward medical liability reform and repeal or repair of the Independent Payment Advisory Board**