



The Department of Health and Human Services Adopts Additional Guidelines for Women's Preventive Services

LEGISLATIVE BRIEF

August 12, 2011

On August 1, 2011, the Department of Health and Human Services (HHS) adopted additional guidelines for Women's Preventive Services, including well-woman office visits; contraception coverage and counseling; breastfeeding equipment and other services listed below. The new guidelines are effective August 1, 2011, but plans are not required to cover the services as preventive services until the first plan year beginning on or after August 1, 2012. The Health Care Reform law (Affordable Care Act or ACA) requires *non*-grandfathered health plans and individual health insurance policies to cover specified preventive services with no cost-sharing by participants (i.e., no co-payment, coinsurance or deductible). The rule applies to all size non-grandfathered plans and to both insured and self-funded plans.

Also on August 1, HHS issued an amendment to the IFRs that allows religious employers who sponsor group health plans to decide whether or not to provide contraception services to participants in their group health plans. This Amendment also applies as of plan years beginning on or after August 1, 2012.

Background

As noted above, the Health Care Reform law requires non-grandfathered health plans and individual health insurance policies to cover specified preventive services with no cost-sharing by participants. The Interim Final Regulations (IFR) issued more than a year ago (July 19, 2010) did not include recommendations for women's preventive services, but stated that guidelines would be issued by August 1, 2011. (The other areas of preventive services that were previously specified included immunizations for routine use; preventive care and screenings for infants, children and adolescents; and items or services with an A or B rating recommended by the U.S. Preventive Services Task Force). The guidelines on women's preventive services were developed by the Institute of Medicine (IOM) and released on July 20, 2011. The Health Resources and Services Administration (HRSA, part of HHS) supports the new guidelines.

Only non-grandfathered health plans (insured or self-funded) and non-grandfathered individual policies are required to cover preventive services with no cost-sharing. The rule applies to all size non-grandfathered plans. There is no "small-plan" exception.

Full List of the Women's Preventive Services that Must be Covered

- Well-woman visits
- Screening for gestational diabetes
- Human Papillomavirus testing
- Counseling for sexually transmitted infections
- Counseling and screenings for human immune-deficiency virus
- All FDA-approved contraceptive methods and counseling
- Breastfeeding support, supplies and counseling
- Screening and counseling for domestic violence.

For HRSA's matrix listing each type of women's preventive service and detailing HHS guidelines for health insurance coverage and the frequency with which these preventive services must be provided, click [here](#).

Next Steps for Employers

- If you sponsor a non-grandfathered group health plan, your plan must provide these women's preventive services with no cost-sharing by the participants as of the first plan year beginning on or after August 1, 2012 (i.e., as of January 1, 2013 for calendar-year plans).
- You may have participants who hear about these new rules on the news and mistakenly think they are effective immediately, so you may need to respond to participant inquiries.
- If you haven't already received notice from your carrier (if you sponsor an insured plan) or your TPA (if you sponsor a self-funded plan), you should check with them and confirm that your plan will be timely amended to provide these new preventive services with no participant cost sharing.
- Once these new rules apply to your plan, make sure your summary plan description and enrollment materials include correct information.

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