



Department of Health and Human Services Issues New Women's Preventive Services Required Health Plan Coverage Guidelines

On August 1, 2011, the Department of Health and Human Services issued new guidelines on women's preventive health.

COMPLIANCE EXCLUSIVE

A Newsletter from SHPS HR Solutions

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On August 1, 2011, the Department of Health and Human Services (“HHS”) issued new guidelines on women’s preventive health (the “guidelines”).¹ Under Section 2713 of the Public Health Service Act (“PHSA”), as added by the Affordable Care Act and incorporated under ERISA, a group health plan and a health insurance issuer offering group or individual health insurance coverage must provide benefits for and may not impose cost-sharing (with certain out of network exceptions) with respect to preventive care and screening provided for under these guidelines. These guidelines supplement the previously adopted preventive care guidelines, and are subject to the same rules regarding cost sharing.²

A group health plan, as defined by the DOL, is an employee welfare benefit plan established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement, or otherwise.³

When are the guidelines effective?

Under the guidelines, non-grandfathered plans and issuers are required to provide the new preventive coverage in the first plan year (or, in the individual market, the first policy year) that begins on or after August 1, 2012. Thus, for non-grandfathered calendar year plans, the guidelines are effective for the plan year beginning January 1, 2013.

What preventive services are covered under the guidelines?

The following preventive services must be offered under the guidelines⁴:

- **Well-woman visits:** Group health plans and health insurance issuers must provide an annual well-woman healthcare visit for adult women to obtain the recommended services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in the guidelines, as well as other preventive care referenced in Section 2713 of the PHSA (such as some routine immunizations).
- **Gestational diabetes screening:** Women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes, should be screened.

¹ See <http://www.healthcare.gov/news/factsheets/womensprevention08012011a.html>

² For more on the preventive care requirements see our prior Employee Benefits Advisory at <http://www.alston.com/files/Publication/bb1750fb-8a95-4dcb-b276-c14a151e19eb/Presentation/PublicationAttachment/c20db36b-b8cf-4245-ac7d-c15734d3dcaa/10-399%20EBEC%20Preventative%20Care%20Coverage.pdf>

³ <http://www.dol.gov/dol/topic/health-plans/index.htm>

⁴ The actual preventive care guidelines can be found at <http://www.hrsa.gov/womensguidelines/>.



The requirements to cover recommended preventive services do not apply to grandfathered health plans. Thus, any plan that remains in grandfathered status will not be subject to the guidelines.

- **HPV DNA testing:** Women who are 30 years of age or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, even if they have normal pap smear results.
- **STI and HIV counseling:** Sexually-active women will have access to annual counseling on HIV and sexually-transmitted infections (“STIs”).
- **Contraception and contraceptive counseling:** Women will have access to all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling. This recommendation excludes abortifacient drugs.
- **Breastfeeding support, supplies, and counseling:** Pregnant and post-partum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment.
- **Domestic violence screening:** Screening and counseling for interpersonal and domestic violence should be provided for all women.

Are there any exceptions to the guidelines?

The requirements to cover recommended preventive services (without any cost-sharing in-network) do not apply to grandfathered health plans. Thus, any plan that remains in grandfathered status will not be subject to the guidelines.

Additionally, the IRS, DOL, and HHS jointly issued an interim final regulation in connection with the guidelines to exempt certain religious employers from the guidelines with regard to contraceptives if their faith deems the provision of contraceptives contrary to its religious tenets. The interim final rule, at 47 CFR § 147.130(a)(i)(iv) provides that certain religious employers are exempt from the requirement to cover contraceptives. A “religious employer” is an organization where (1) the inculcation of religious values is the purpose of the organization; (2) the organization primarily employs persons who share the religious tenets of the organization; (3) the organization serves primarily persons who share the religious tenets of the organization; and (4) the organization is a nonprofit organization as described in Section 6033 of the Internal Revenue Code. The federal exemption for religious employers was modeled on state exemptions that are already in force in a number of states that already require contraceptive services coverage.

The exemption for religious employers applies only to group health plans sponsored by certain religious employers and group health insurance offered in connection with such plans. Health insurance issuers in the individual market must provide contraceptive services coverage.



About the Author



John Hickman is head of Alston & Bird's Health Benefits Practice where he leads five attorneys devoted exclusively to HIPAA privacy, flexible benefits, and other health and welfare benefit issues. He has been a pioneer in the consumer-directed healthcare arena and has worked closely with health plans, financial institutions and employers as well as the Internal Revenue Service, Treasury, and

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