

Health Care Reform at Six Months: New Protections In Place for Reproductive Health

The end of September marked the six-month anniversary of the official enactment, with the president's signature, of the Patient Protection and Affordable Care Act—better known as health care reform. It also was the effective date for a number of new provisions designed to expand the rights of patients under private health insurance, providing incremental, stop-gap improvements in the interim between the law's passage and the 2014 start date for the legislation's expansive changes to Medicaid and the private insurance market. Several of these provisions should have a substantial impact in the short term on the ability of women and men to meet their reproductive health care needs—although even there, important questions have not been fully answered.

Preventive Services

Among the most important of these early provisions is one that requires all new private health plans in the country to cover a range of preventive health services without any out-of-pocket costs to consumers, such as copayments or deductibles. The initial list of protected services—based on three sets of existing government-supported guidelines—includes many related to reproductive health, including breast and cervical cancer screening, screening and counseling for HIV and several other sexually transmitted infections (STIs), vaccination for human papillomavirus, numerous aspects of prenatal care, and pediatric care that for adolescents includes counseling for reproductive health issues. These protections took effect on September 23, although in practice they will be

phased in more gradually, for two reasons: First, they become effective only at the beginning of a new plan year, which for most group plans is January 1. Second, plans are “grandfathered”—exempt from the requirement—so long as no significant, negative changes, such as cutting benefits or raising cost-sharing, are made to them.

The list of protected preventive services will be expanded sometime next year when an Institute of Medicine panel develops a fourth set of guidelines: more comprehensive recommendations for women's preventive health care, required under an amendment to the legislation authored by Sen. Barbara Mikulski (D-MD) that was intended by its supporters to include contraceptive counseling, services and supplies (related article, Spring 2010, page 2). Preliminary regulations to implement the provision set a target date of August 2011 for the guidelines to be completed, although several factors may conspire so that contraception, if ultimately required, would not be guaranteed without cost-sharing under most new plans until January 2013—two years after the rest of the provision's requirements. Numerous reproductive health advocates and providers submitted comments to express their support for the provision and suggest ways to expedite the implementation of the women's health recommendations and ensure that they are appropriately crafted to reflect current, reputable scientific evidence, the legislative history of the amendment and precedents in federal law and policy. They also recommended changes and additions to the

rules to monitor, enforce and encourage compliance with the provision's requirements and protect women and men from insurance industry practices that could undermine the goal of maximizing the use of effective preventive care.

Expanding Patients' Rights

September 23, in fact, brought with it the start of a host of provisions creating new rights and protections for patients in the private insurance market, many of them labeled collectively as a “Patient's Bill of Rights.” Among other things, new health plans are prevented from imposing lifetime caps on coverage, while annual limits on coverage are being phased out over the next several years; plans are prohibited from rescinding coverage—retroactively canceling it—except in cases of fraud; and children may not be denied or limited in their coverage because of preexisting medical conditions, a protection that will be extended to adults in 2014.

Two of the provisions are particularly relevant for improving access to reproductive health care. First, all new private plans—excluding those with grandfathered status—are now required to allow women to visit a specialist for obstetric or gynecologic care without first receiving a referral from a primary care provider or prior authorization from the insurer. Thirty-six states and the District of Columbia had similar policies, commonly known as “direct access” laws, in place as of 2008, according to the Kaiser Family Foundation, but those do not apply to employers that self-insure their employees.

Second, private plans that provide dependent coverage of children must now extend that coverage to adult children younger than age 26. Previously, plans in most states ended coverage for children under their parents' policies when they turned 19 or graduated from college. Historically, young adults have been the age-group most likely to lack health insurance coverage. And when it comes to reproductive health, individuals aged 18–24 have the highest rate of unintended pregnancy; in this age-group, more than one unintended pregnancy occurs for every 10 women, a rate twice that for women overall. Young adults also have the highest STI rates. This provision should help extend coverage and access to care for many young adults over the next few years and may be the best avenue for covering some of them even after new insurance options are available in 2014. Reproductive health advocates, however, have pointed to one significant obstacle to accessing care that will be magnified with the expansion of dependent coverage. That is, private plans' claims-processing procedures may inadvertently undermine confidentiality, notably by sending an explanation-of-benefits form to the policyholder (who may be a parent or spouse) when a dependent receives services under the policy (related article, Fall 2009, page 12). Additional

federal regulation may be needed to address the disconnect between these claims procedures and confidentiality rights.

Marketplaces for Coverage

October 1 brought with it the second phase of another key component of health care reform: a nationwide Internet portal through which individuals and small businesses can obtain information about the insurance options available to them locally. The Department of Health and Human Services rolled out a preliminary portal in July, providing basic, readily available information about plans in the individual and small group markets, as well as other private and public options. The new, second-stage portal includes more detailed pricing and benefit information, allowing consumers to compare plans in terms of premiums, cost-sharing options and, in some cases, types of services covered. The degree of information and transparency included holds considerable promise for helping consumers identify and choose a plan that meets their needs. However, the current version is limited in the information it provides on coverage of and limitations on reproductive health services: consumers can search for plans that cover maternity care, and for some plans, the portal includes a link to the drug formulary, potentially allowing

one to see what specific contraceptive drugs are included.

This federal Internet portal is intended to serve as a precursor and model for the insurance exchanges slated to start up in 2014, and in fact, the administration is already laying the groundwork for the more extensive set of regulations necessary to help states prepare for that crucial deadline. October 4 was the closing date for an initial, pre-regulatory request for comments that was issued in August that asked for public input on a vast array of questions related to how the exchanges should be designed and operated. The eventual answers could influence a range of reproductive health-related concerns, such as the implementation of the law's requirement that health plans include safety-net providers, including family planning centers, in their provider networks. These answers could also impact the degree to which plans in the exchanges provide abortion coverage in the face of the law's restrictions on coverage of that procedure; indeed, the administration clearly has that politically charged issue on its mind, as it released its first, initial guidance for states and insurers on that front in September (related article, page 2).—*Adam Sonfield*