

Beyond Contraception: The Overlooked Reproductive Health Benefits of Health Reform's Preventive Services Requirement

By Adam Sonfield

One of the most highly publicized provisions of the Affordable Care Act (ACA) is the requirement that most private health plans provide coverage of contraceptive methods and counseling without additional out-of-pocket costs, such as copayments and deductibles. That requirement—and the controversy ginned up by social conservative opponents of contraception, who have declared the requirement a violation of religious rights—has been repeatedly debated in the media, the courts, Congress, state legislatures and the 2012 political campaigns. As health plans phase in that coverage over the next year and beyond, it seems all but certain that the public will hear a great deal about the new contraceptive benefits guaranteed to them.

Less certain, however, is how much the public will learn about dozens of other preventive care services that these same plans must also cover without patient cost-sharing. That same provision of the ACA, codified into federal law as Sec. 2713 of the Public Health Service Act, encompasses four sets of recommendations for preventive care that range from basic screenings for heart disease and diabetes to a full slate of childhood and adult vaccinations to fluoride supplements for children without fluoride in their water source. Three of those sets of recommendations—those of the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices, and the American Academy of Pediatrics' *Bright Futures* pediatric guidelines—were in place before the ACA was enacted and became binding on many health plans starting in September 2010. The fourth set, recommenda-

tions on women's preventive health care, including contraception, were developed by a panel of the Institute of Medicine (IOM) after the ACA was enacted and became binding for many plans starting in August 2012. The requirements for health plans will evolve over time, automatically incorporating updates made to these four sets of recommendations in response to new evidence and new technologies and practices.

Taken together, the ACA's preventive services requirements include a wide array of services beyond contraceptive care that are central to the sexual and reproductive health of women. They include screenings and vaccination to prevent cervical cancer, counseling and screenings to prevent HIV and other sexually transmitted infections (STIs), a wide range of maternity care services and the preventive care visits needed for women to access this all. They also include a somewhat less robust package of sexual and reproductive health services for men. The requirements to cover these services without patient cost-sharing have the potential to close key gaps in care. Yet, for the requirements to achieve their full potential, further guidance from the federal government may be needed to curb insurance industry practices that could undermine the impact of the requirements.

Cervical Cancer Prevention

Cervical cancer is the third most common cancer among women worldwide, with more than half a million new cases each year.¹ Many years ago, it was the leading cause of cancer deaths among U.S. women, but in 2008, there were only 12,400 new diagnoses and 4,000 deaths from the disease.² The decline, according to the federal gov-

ernment, is largely the result of regular Pap tests, which can identify precancerous conditions in the cervix early enough for them to be treated safely and effectively (see “Preventing Cervical Cancer: New Resources to Advance the Domestic and Global Fight,” Winter 2012).

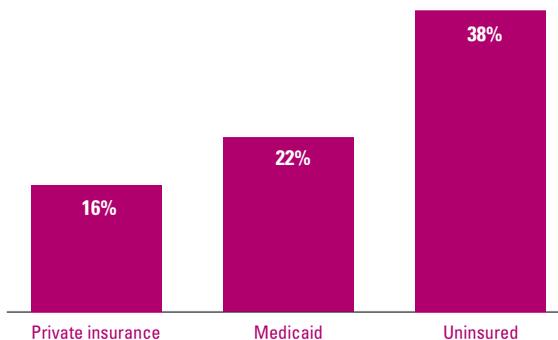
The ACA’s preventive services provision requires coverage without cost-sharing of three services to help further reduce the U.S. incidence of cervical cancer. First, it requires coverage of Pap tests, following current recommendations for testing every three years among women aged 21–65.³ As of 2010, before the ACA provision took full effect, the CDC estimates that large numbers of U.S. women had not had a Pap test in the past three years, including nearly four in 10 uninsured women aged 18–64 (see chart).⁴ Most cases of cervical cancer occur among women who have not had recommended Pap tests and follow-up care.³

Second, the ACA provision requires coverage of a newer screening technology: simultaneous testing for high-risk strains of the human papillomavirus (HPV), which are the root cause of virtually all cases of cervical cancer. HPV is extremely prevalent in younger women, but usually resolves spontaneously. To avoid unnecessary treatment, this screening for HPV must only be covered for women beginning at age 30 and no more frequently than every three years, in conjunction with a Pap test.⁵

The third cervical cancer prevention service required under the ACA provision is for another recent advance, HPV vaccination. Since 2006, the U.S. Food and Drug Administration has approved two vaccines, Gardasil and Cervarix, that provide protection against two viral strains that cause the large majority of cervical cancers and are linked with anal, throat and other cancers as well. Gardasil has also been demonstrated effective against two additional viral strains that account for 90% of all genital warts. Because the vaccines do not clear existing infections and because HPV is so common among sexually active teens and adults, the three-dose vaccination is recommended for preteen girls, aged 11–12.⁶ The vaccines could be started as early as age 9, and must also

PAP GAP

In 2010, nearly four in 10 uninsured women aged 18–64 had not had a Pap test within the past three years, a rate that was more than twice that of privately insured women.



Source: reference 4.

be covered as a “catch up” for women through age 26, if they were not previously vaccinated.

Coverage without cost-sharing of the expensive HPV vaccine could improve rates that lag far behind those for most other vaccines in the United States. A 2010 CDC survey found that only 49% of women aged 13–17 had received at least one dose of HPV vaccine, and only 32% had received all three doses.⁷ Despite the slow take-up in the United States, the vaccine appears to already be providing some degree of “herd immunity” for unvaccinated women as well, according to a study released in July 2012.⁸

HIV and STI Prevention

Although HPV is among the most common STIs, there are numerous others that affect Americans’ health and fertility. Accurate and up-to-date statistics on the incidence and prevalence of these infections are difficult to come by: The state and federal governments conduct surveillance for only a few types of STIs and even then, under-reporting is a persistent problem, in part because many infections go undiagnosed. The most recent estimates—more than a decade old—suggest that there are about 19 million new cases of STIs each year, half of them among 15–24-year-olds, and that 65 million Americans have at least one viral STI, most commonly genital herpes.^{9,10}

Insurance plans governed by the ACA’s preventive services provision must provide cost-

sharing-free coverage of a series of services intended to help prevent the spread of STIs. First, counseling on HIV and other STIs must be covered for all sexually active women.⁵ Coverage of STI counseling could help to encourage better clinician-patient communication on the subject. A 2008 study found that only 28% of women aged 18–44 reported having discussed STIs with a doctor or nurse in the past three years, and only 38% had discussed their sexual history (see chart).¹¹

Also required under the ACA provision is screening for four specific STIs: HIV, chlamydia, gonorrhea and syphilis. Each of those requirements is tied to a different set of populations, based on current evidence around need and effectiveness. Annual HIV screening must be covered for all sexually active women.⁵ Screening for chlamydia and gonorrhea must be covered for all sexually active women younger than 25, as well as older women assessed to be at increased risk.^{12,13} Syphilis is rare enough in most U.S. populations that screening must only be covered for women at highest risk, such as commercial sex workers.¹⁴

Improved coverage of STI screening may help improve current rates of testing. In 2011, 44% of 18–64-year-olds in the United States reported never having been tested for HIV.¹⁵ Similarly, 68%

of women 18–49 reported that they had not had a test for an STI in the past two years, according to a 2008 study.¹¹

Finally, the ACA provision encompasses vaccination for hepatitis A and B. Both of those infections, which can lead to serious liver disease, are sometimes transmitted sexually.⁶

Protecting Maternal and Infant Health

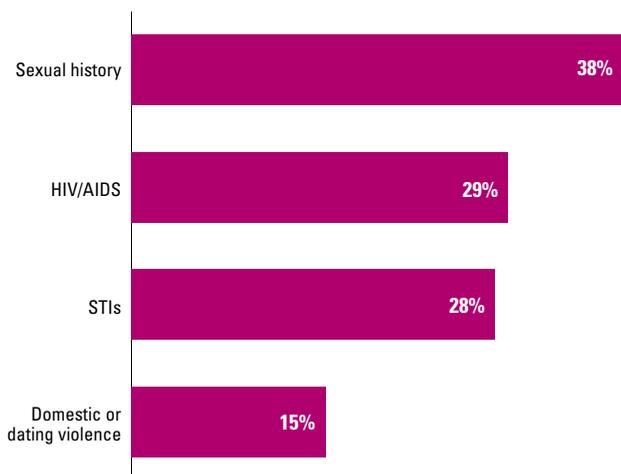
Current medical standards include a host of recommendations to improve maternal and infant health outcomes, to prevent not only maternal and infant deaths (which are rare in the United States), but also considerably more common conditions, such as diabetes and depression, that can be triggered in pregnant women, and developmental problems and infections in infants. Appropriate preconception, prenatal and postpartum care can help prevent many of these problems.

Based on recommendations from the IOM panel, the ACA’s preventive coverage provision requires coverage for preconception and prenatal care visits. For preconception care, the panel specified that a visit should provide “counseling and guidance for preconception health,” along with “evidence-based tests, procedures, and screening for nonpregnant women to optimize reproductive outcomes and prevent or optimize treatment for chronic conditions.”⁵ In addition, the ACA provision requires coverage of a daily folic acid supplement for “all women planning or capable of pregnancy,” to reduce the risk for neural tube defects, if they were to become pregnant.¹⁶

Most of the pregnancy-related services that must be covered under the ACA’s preventive services provision are recommended aspects of prenatal care. This includes prenatal care visits, which should, according to the IOM panel, provide “counseling and guidance for prenatal care,” as well as “evidence-based tests, procedures, and screening for pregnant women to optimize birth outcomes and future chronic conditions.”⁵ Requiring coverage without cost-sharing for these visits—more than a dozen over the course of a pregnancy—may remove a sizable financial impediment to care for low-income women.

LEFT UNSPOKEN

Few U.S. women aged 18–44 report having discussed key reproductive health-related topics with a doctor or nurse in the past three years.



Note: 2008 data. Source: reference 11.

According to data from 27 states and territories, only 71% of pregnant women received prenatal care in the first trimester in 2008, and that rate was particularly low for young and minority women.¹⁷

In addition to the visit itself, the ACA requirements specifically include:

- screening and counseling for alcohol misuse, to help prevent fetal alcohol syndrome;¹⁸
- screening, counseling and cessation interventions for tobacco use, which is tied to premature birth and stunted fetal growth;¹⁹
- screening for gestational diabetes, which occurs in approximately 2–10% of pregnant women;⁵
- screening for Rh incompatibility, which if unaddressed can lead to severe complications for the infant;²⁰
- screening for iron deficiency anemia, which is linked to such problems as low birth weight, pre-term delivery, postpartum depression and developmental problems for infants;²¹
- screening for various STIs, which can be transmitted to newborns and lead to complications including blindness;¹³ and
- screening for suicidal thoughts and postpartum depression in pregnant and postpartum women (which the IOM panel declined to identify as a discrete recommendation but was included in its list of services that should be included in preventive care visits).⁵

Finally, the ACA provision requires coverage of one key aspect of postpartum care: counseling, education and support for breastfeeding by a trained provider, along with the costs of renting breastfeeding equipment.⁵ Requiring coverage of breast pumps is particularly groundbreaking and may make it far more affordable than it is today for low-income working women to continue breastfeeding. Although 77% of new mothers began breastfeeding in 2009, only 47% continued through six months, and only 26% through 12 months (see chart).²²

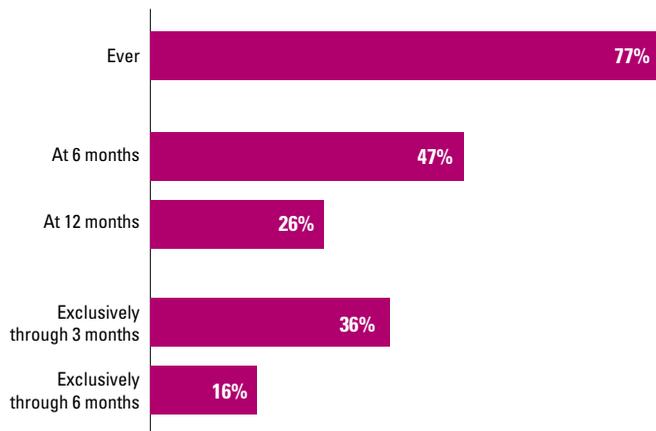
Preventive Care Visits

The ACA provision requires coverage of one final thing intended to draw all of these services together for women: the preventive care visit itself. Private health plans will need to cover, without out-of-pocket costs, “at least one well-woman preventive care visit annually for adult women to obtain the recommended preventive services.”⁵ Moreover, the requirement, as detailed in a recommendation from the IOM panel, specifies 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.” For example, many women have annual visits to both a family physician and an obstetrician-gynecologist to obtain different sets of preventive care services. Preconception care and prenatal care also potentially require additional visits. This requirement will help to eliminate a problem in some plans today: that they have coverage limited to a single preventive visit each year.

These preventive care visits are intended to be the opportunity for clinicians to provide all of the other recommended services and counseling. That includes additional coverage requirements that are of particular note for sexual and reproductive health: screening and counseling for women for interpersonal and domestic violence,⁵

DIFFICULT TO SUSTAIN

Most new mothers today do begin breastfeeding, but few do so exclusively or for a full year.



Note: 2009 data. Source: reference 22.

and for adolescents, screening and counseling about “coercive and abusive relationships,” and about fostering healthy dating relationships and avoiding violence.²³

In recommending this type screening and counseling, the IOM panel cited a wide range of statistics on the prevalence of physical, emotional and sexual abuse by intimate partners, with 1–5 million women affected each year.⁵ Beyond the violence itself, women and men can face such additional reproductive health consequences as pressure to engage in high-risk sexual activities, HIV and other STIs, unwanted pregnancy, and coercion to use or forgo contraception or abortion. Despite all of these serious health consequences, only 15% of women aged 18–44 in 2008 reported that they had discussed this topic with a doctor or nurse in the past three years.¹¹

Men’s Preventive Care

Notably, the ACA’s preventive care provision draws on comprehensive recommendations for women and adolescents, but for adult men, it draws only on the more limited sets of recommendations from the U.S. Preventive Services Task Force and the CDC’s immunization panel. As a result, the ACA’s coverage requirements are somewhat less comprehensive for adult men than they are for women and adolescents, and that could lead to several disparities in coverage. For example, HIV screening and counseling on HIV and other STIs are only required to be covered for adult men who are deemed to be at high risk (based on factors such as their sexual behavior and the STI prevalence in their community), rather than for all who are sexually active.^{24,25} In addition, there is no coverage requirement for men’s preventive care visits. Rather, under the regulations issued by the Department of Health and Human Services (DHHS) to interpret this provision, an office visit for a man would only have to be exempt from patient cost-sharing if the “primary purpose” of the visit were for specific recommended preventive care services.²⁶

In practice, these potential disparities may not emerge. It is unclear whether and why plans would make these types of fine distinctions

between women and men in their coverage standards. Public documents from several major insurers, including UnitedHealthcare, Cigna and Anthem Blue Cross Blue Shield, indicate that they are covering men’s preventive care visits to the same extent as they are covering women’s.^{27–29}

One area where a disparity does seem likely is contraception: DHHS has asserted that male contraceptive methods, such as vasectomies and condoms, need not be covered.³⁰ This position seems particularly short sighted, and insurers should consider covering these services without cost-sharing anyway. Vasectomy is less expensive and less invasive than female sterilization, so it benefits no one to provide economic incentives for couples to choose female sterilization. Moreover, contraceptive methods used by men and by women offer the same benefits for women’s health, stemming from the prevention of unplanned pregnancies and the ability to time and space planned ones.

One piece of bright news for men’s preventive health coverage came in December 2011, when the CDC adopted an updated recommendation that endorsed HPV vaccination (Gardasil specifically) for males.⁶ Vaccination for males—coverage of which will now be required under the ACA provision—is intended both to protect them against reproductive cancers and genital warts, and to help provide protection for their female partners.

Refining the Fine Print

Beyond the potential disparities between coverage for men and women, the ACA’s preventive services requirements do come with several caveats. First, not all private-sector health plans must comply with the requirements—at least, not immediately. Existing plans are “grandfathered” (exempt from the requirements) so long as no significant negative changes, such as benefit reductions or cost-sharing increases, are made to them. In addition, for plans that are not grandfathered, there is an additional delay for new requirements, which do not take force until a year after a recommendation is adopted. In practice, that delay may be longer than a year, because new requirements become effective only at the

beginning of a new plan year, which for most group plans is January 1. For example, the new recommendation for male HPV vaccination will become officially binding for insurance plans a year from when it was adopted late in 2011—so, effectively, in January 2013 for most group plans.

None of this, of course, precludes insurance companies or self-insured employers from adjusting their coverage standards earlier, and some companies may find it preferable to have the same standards across all their plans, whether or not they could claim grandfathered status. Moreover, these delays should essentially resolve themselves, with all plans eventually losing their grandfathered status; indeed, the federal government has projected that most plans will lose this grandfathered status by 2013.³¹

Second, the statute does allow for health plans to make use of restrictions and requirements designed to improve the “value” of coverage. Federal regulations have interpreted this to mean that plans may use “reasonable medical management techniques to determine the frequency, method, treatment, or setting” of a covered service, but they provide little guidance on what might be “reasonable.”²⁶ The one clear example given is that health plans can impose cost-sharing or deny coverage entirely if provided by clinicians, pharmacies or suppliers not in their network. This guidance is not especially surprising, as plan networks are a basic component of modern health insurance. However, further DHHS guidance could be helpful to make it clear that out-of-network access must be allowed if covered services are not accessible in-network, and that cost-control techniques must not take precedence over patients’ health needs.

Moreover, when left to their own devices, insurers may take actions that more concretely undermine the provision’s intent and goals. For instance, public documents from several insurers, including UnitedHealthcare, Aetna and Kaiser Permanente, indicate that they are taking the position that they must only cover counseling about folic acid supplements, but not the supplements themselves—despite the unambiguous requirement on this subject.^{32–34} Federal oversight

and enforcement of the ACA’s preventive care provision could head off these types of actions and help maximize the provision’s impact on the sexual and reproductive health of insured women and men throughout the United States.

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