Frequently Asked Questions about Women's Health & the Affordable Care Act

How does the Affordable Care Act (ACA) change health insurance coverage for women?

Insurance companies can't make you pay higher premiums just because you're a woman. Also, all new plans must cover the 10 essential health benefits (EHBs)--the types of services that must be covered under each plan. Many of the EHBs are especially great for women.

What are the EHBs my insurance plan must cover?

-***Ambulatory Patient Services*** - care you get without being admitted to a hospital

-***Emergency Services*** - services in the ER

-***Hospitalization*** - when you have to stay overnight at hospital

-***Maternity and Newborn Care*** - care before and after your baby is born

-*Mental Health & Substance Use Disorder Services* - services like treatment for alcohol abuse or depression

-***Prescription Drugs*** - medicines prescribed by your doctor

-***Rehabilitative and Habilitative Services*** - services to help people gain or recover skills, such as physical or speech therapy

-***Laboratory Services*** - blood tests

-***Pediatric Services (including dental and vision)*** - like check ups, immunizations, teeth cleanings, glasses

-***Preventive Wellness Services & Chronic Disease Management*** - services like birth control, flu shots, well-woman check

Unless your plan is "grandfathered" -- if it existed before the ACA -- it has to cover the EHBs. Most plans aren't grandfathered, and eventually all plans will have to follow these rules. You can find out if your plan is grandfathered by contacting your insurance company.

What preventive services does my insurance plan have to cover without cost sharing?

All new plans must cover certain preventive services -- services to keep you healthy and from getting sick -- without cost sharing. This means you can get the services without a copay or having costs applied to your deductible. Some preventive services are:

-Well women visits and gynecological exams (pap smears)

-Breastfeeding support, supplies, and counseling

-Birth control and counseling

-STI counseling

-Various screenings and tests Vaccinations, including shots for the flu, HPV, and Hepatitis

-Programs to help you quit smoking

Does my insurance have to cover maternity care or breastfeeding services?

Your plan must cover prenatal care (care before your baby is born), labor and delivery, and postpartum care (care after your baby is born). It must also cover breastfeeding support and supplies, like breast pumps and lactation counseling. Breastfeeding support and supplies, including renting or buying breastfeeding equipment, have to be covered without cost sharing throughout the duration of your pregnancy.

I heard my insurance has to cover birth control for free. Is this true?

Plans must cover one of each type of birth control approved by the federal Food and Drug Administration (FDA) without cost-sharing. These types include birth control pills, sterilization surgery, IUDs, diaphragms, implants, cervical caps, sponges, shots/injections, patches, vaginal rings, and emergency contraception. Your plan also has to cover services connected to getting birth control, like a counseling appointment with your doctor.

But, how this works is a little trickier than it sounds, and you could have trouble getting the exact treatment you need without cost sharing. This is because plans only have to cover ***one form of each type*** of birth control without cost sharing. For example, a plan could cover only one brand of patch without cost sharing. A plan could cover just generic, not name brand products, without cost sharing. Or, a plan could create a list of birth control pills covered without cost sharing, but the pill your doctor prescribed may not be on that list.

What can I do if my insurance company tells me they won't cover the type of birth control my doctor prescribed for free?

Your doctor prescribed something that is right for you and your health needs, but your insurance company says it isn't covered without cost sharing. In this situation, the insurance company must have an easily accessible process --called a "waiver process" -- where you can get what your doctor prescribed without cost sharing.

For example, based on your health history, your doctor prescribed a name brand birth control pill, but your plan only covers generics without cost sharing. If your doctor determined a generic pill isn't right for you, there has to be a waiver process to get the name brand pill for free.

What if my insurance company refuses to cover a preventive service--like a flu shot or a well-woman visit--without cost sharing?

You can find out about what your plan covers in materials you got when you signed up or on the insurance company's website. You can also call your insurance company and ask why you're charged cost sharing. You may be able to resolve issues by just calling and asking questions.

It's good to keep records while trying to get a service covered without cost sharing to help prove what you're being required to pay and the explanations for the charges. Keep bills, statements, receipts, and letters from your doctor, pharmacy, and insurance company. Take notes of conversations you have with these places.

Also, if you disagree with a decision by your insurance company, you can go through the company's appeal process through which the company reviews the decision. You can find information about this process in your plan materials or on the insurance company's website.

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