



To: Division of Insurance  
From: Elisa Cafferata, President & CEO NAPPA  
Re: **Essential Health Benefits**  
Date: September 27, 2012

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Thank you, once again, for the opportunity to provide input into this critical process. We appreciate all of the work that the Division of Insurance has put in to get the Health Insurance Exchange up and running.

Planned Parenthood's five Nevada health centers handle approximately 50,000 patient visits each year in our state. Over 95% of the services we provide are of reproductive health care services, including: birth control and family planning, sex education, gynecological care, sexually transmitted infection (STI) testing and treatment, pregnancy testing and referrals for prenatal care.

We have been active participants in the creation of the Health Insurance Exchange on behalf of our clients who, by and large, do not have health insurance. They will be directly benefitted by the creation of the Exchange.

On the topic of Essential Health Benefits, we have two goals:

1. We have several specific recommendations to address the issue of non-discrimination as the Essential Health Benefits are decided and the Exchange portal is built.
2. We want to provide an overview of the benefits for women in each of the plans (Attachment B) with a reminder that "maternity and newborn care" is one of the 10 Essential Health Benefits and that every Qualified Health Plan is required to provide coverage without cost-sharing consistent with the Women's Preventive Services guidelines (Attachment A).

**Non-discrimination within the Exchange:**

Exchanges must comply with all applicable federal statutes relating to nondiscrimination. And we would add compliance with state statutes relating to nondiscrimination as well. In 2011, the Nevada Legislature passed three transgender equality bills, including a law prohibiting discrimination in public accommodations. Health care facilities are included in public accommodations under the law.

Regulations issued by the federal Department of Health and Human Services in March 2012 explicitly prohibit discrimination on the basis of gender identity in all activities of the exchange, as well as the activities of qualified health plan (QHP) issuers with regard to their QHPs. Accordingly, QHP issuers are prohibited from offering QHPs that discriminate on the basis of gender identity by denying transgender consumers coverage for services that are covered for non-transgender consumers.

**Recommendation:** Require coverage of domestic partners as dependents for QHPs. Currently:

- **Plan A1 - HPN Group 1 POS C-XV-500 HCR / Plan A2 – HPN EOC:** Only covers “legal spouse”
- **Plan D – NV PEBP PY2012 MPD:** Covers “domestic partners”
- **Plan F1 – HHP Benefit Summary:** Covers “lawful spouse” and “lawful domestic partner”
- ***Specifically:*** Require QHPs to provide coverage of dependents and to include “spouse and domestic partners” in the definition of “dependents.”

**Recommendation:** Include tools to allow LGBTQ Nevadans to learn about coverage of interest to them.

- The Federal website, healthcare.gov, is designed to help all consumers find the health coverage best suited to their needs, makes it easier to locate insurers that cover same-sex domestic partners by including a “same-sex domestic partner” filter within its health coverage finder. The filter allows couples to eliminate plans that would not cover both of them from the list of plans available in their area.
- ***Specifically:*** The SS HIX business solution / web portal should include tools to make it easier for LGBTQI Nevadans to find insurance plans that cover same-sex domestic partners.

**Recommendation:** Apply LGBTQ nondiscrimination protections to any plan required to cover the essential benefits.

- The SS HIX Board should apply nondiscrimination protections to any plan required to cover the essential benefits, including those in the individual and small group markets outside the exchange. For example, at least one of the plans being considered (**Plan F1 – HHP**) specifically excludes “any procedure or treatment designed to alter physical characteristics of the member to those of the opposite sex.”
- ***Specifically:*** QHPs may not discriminate on the basis of sexual orientation or gender identity. QHP issuers are prohibited from offering QHPs that discriminate on the basis of gender identity by denying transgender consumers coverage for services that are covered for non-transgender consumers.

**Provide coverage without cost-sharing consistent with the Women’s Preventive Services guidelines:**

The Affordable Care Act includes “maternity and newborn care” as one of the 10 Essential Health Benefits. Every Qualified Health Plan is also required to provide coverage without cost-sharing consistent with the Women’s Preventive Services guidelines (Attachment A). We have provided a brief summary of major areas of women’s health care for you to use as you consider choosing an Essential Health Benefits plan. (Attachment B).

Specifically, we have the following concerns about the benefits listed in the plans being considered (based on our reading of the Explanation of Benefits, which may not be accurate):

- **Plan F1 – HHP** limits amniocentesis ...in the first 16 weeks for genetic testing for the purpose of determining the need for fetal therapy or to determine a medically necessary intervention for the mother.
- Only **Plan D – NV PEBP PY2012 MPD** will consider Prophylactic (mastectomy) Surgery in certain circumstances.

- **Plan D – NV PEBP PY2012 MPD** has a limitation that “birth control pills and diaphragms as well as contraceptive injectables such as Depo-Provera and Lunelle are subject to the plan year deductible.”

**Recommendation:** Affirm that “maternity and newborn care” is one of the 10 Essential Health Benefits and that every Qualified Health Plan is required to provide coverage without cost-sharing consistent with the Women’s Preventive Services guidelines.

## ATTACHMENT A

### **Health Resources and Services Administration-Supported Women's Preventive Services: Required Health Plan Coverage Guidelines<sup>1</sup>**

These guidelines are effective August 1, 2011. Accordingly, non-grandfathered plans and issuers are required to provide coverage without cost sharing consistent with these guidelines in the first plan year (in the individual market, policy year) that begins on or after August 1, 2012.

| <b>Type of Preventive Service</b>                           | <b>HHS Guideline for Health Insurance Coverage</b>  | <b>Frequency</b>  |
|---|---|---|
| Well-woman visits.  | Well-woman preventive care visit annually for adult women to obtain the recommended preventive 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 this set of guidelines, as well as others referenced in section 2713. | Annual, although HHS recognizes 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.* |
| Screening for gestational diabetes.                         | Screening for gestational diabetes.   | In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.   |
| Human Papillomavirus testing.                               | High-risk human Papillomavirus DNA testing in women with normal cytology results.   | Screening should begin at 30 years of age and should occur no more frequently than every 3 years.   |
| Counseling for sexually transmitted infections.             | Counseling on sexually transmitted infections for all sexually active women.  | Annual.   |
| Counseling and screening for human immune-deficiency virus. | Counseling and screening for human immune-deficiency virus infection for all sexually active women.   | Annual.   |
| Contraceptive methods and counseling.**                     | All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with  | As prescribed.  |

<sup>1</sup> <http://www.healthcare.gov/law/resources/regulations/womensprevention.html>

|   |  |                                 |
|---|--|---------------------------------|
|   | reproductive capacity.   |                                 |
| Breastfeeding support, supplies, and counseling.                  | Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment. | In conjunction with each birth. |
| Screening and counseling for interpersonal and domestic violence. | Screening and counseling for interpersonal and domestic violence.  | Annual.                         |

\* Refer to recommendations listed in the July 2011 IOM report titled Clinical Preventive Services for Women: Closing the Gaps concerning individual preventive services that may be obtained during a well-woman preventive service visit.

\*\* Group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to cover contraceptive services. A religious employer is one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization under Internal Revenue Code section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii). 45 C.F.R. §147.130(a)(1)(iv)(B).

**ATTACHMENT B.**  
**SUMMARY OF WOMEN'S HEALTH SERVICES IN PLANS BEING CONSIDERED AS BENCHMARK**  
**FOR ESSENTIAL HEALTH BENEFITS IN THE SILVER STATE HEALTH INSURANCE EXCHANGE**

**Maternity:**

**All three plans:**

Comply with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. Federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

**Plan A1 - HPN Group 1 POS C-XV-500 HCR / Plan A2 – HPN EOC:**

- **Exclusions:** Amniocentesis, except when Medically Necessary under the guidelines of the American College of Obstetrics and Gynecology.

**Plan D – NV PEBP PY2012 MPD:**

- **Covers:** Amniocentesis, chronic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in pregnant women only if the procedure is medically necessary as determined by the Plan Administrator or its designee.

**Plan F1 – HHP Benefit Summary:**

- **Exclusions:** Amniocentesis (except when done in the last trimester for the purpose of determining fetal lung maturity) in the first 16 weeks for genetic testing for the purpose of determining the need for fetal therapy or to determine a medically necessary intervention for the mother.

**Mastectomy:**

**All three plans:**

Comply with the Women's Health and Cancer Rights Act, any covered individual who is receiving benefits from a mastectomy who elects breast reconstruction in connection with it, coverage is provided for:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- prostheses and physical complications for mastectomy, including lymphedemas

Reconstructive surgery if such procedures are intended to improve bodily function or to correct deformity from disease, infection, trauma, congenital anomaly, or results from a covered therapeutic procedure.

**Plan A1 - HPN Group 1 POS C-XV-500 HCR / Plan A2 – HPN EOC:**

**Plan D – NV PEBP PY2012 MPD:**

- Prophylactic Surgery considered in certain circumstances.

**Plan F1 – HHP Benefit Summary:**

**Family Planning:** (Contraceptive methods and counseling are covered by the Women's Preventive Services guidelines)

**Plan A1 - HPN Group 1 POS C-XV-500 HCR / Plan A2 – HPN EOC:**

- family planning services including sterilization procedures

**Plan D – NV PEBP PY2012 MPD:**

- Medical or surgical treatment of sexual dysfunction
- Surgical sterilization procedures are subject to the plan year deductible.
- Birth control pills and diaphragms are subject to the plan year deductible.
- Contraceptive injectables such as Depo-Provera and Lunelle are subject to the plan year deductible.

**Plan F1 – HHP Benefit Summary:**

- Birth control drugs, devices and implants except as set forth in a prescription drug rider or in this EOC.

**OB/GYN:** (Well-woman visits covered by Women's Preventive Services guidelines)

**All three plans** will be required to cover women's preventive health care – such as mammograms, screenings for cervical cancer, and other services –with no cost-sharing. (See Attachment A.)

**IVF:**

**Plan A1 - HPN Group 1 POS C-XV-500 HCR / Plan A2 – HPN EOC:**

- Limited diagnostic and therapeutic infertility services determined to be Medically Necessary and Prior Authorized by HPN's Managed Care Program. Covered Services do not include those services specifically excluded herein, but do include limited:
  - Laboratory studies;
  - Diagnostic procedures; and
  - Artificial insemination services, up to six (6) cycles per Member per lifetime.
- **The following infertility services and supplies are excluded**, in addition to any other infertility services or supplies determined by HPN not to be Medically Necessary;
  - Advanced reproductive techniques such as embryo transplants, in vitro fertilization, GIFT and ZIFT procedures, assisted hatching, intracytoplasmic sperm injection, egg retrieval via laparoscope or needle aspiration, sperm preparation, specialized sperm retrieval techniques, sperm washing except prior to artificial insemination if required;
  - Home pregnancy or ovulation tests;
  - Sonohysterography;
  - Monitoring of ovarian response to stimulants;
  - CT or MRI of sella turcica unless elevated prolactin level;
  - Evaluation for sterilization reversal;
  - Laparoscopy;
  - Ovarian wedge resection;
  - Removal of fibroids, uterine septae and polyps;

- Open or laparoscopic resection, fulguration, or removal of endometrial implants;
- Surgical lysis of adhesions;
- Surgical tube reconstruction.

**Plan D – NV PEBP PY2012 MPD:**

- No coverage for the treatment of fertility or infertility.

**Plan F1 – HHP Benefit Summary:**

- **Exclusions:** The promotion of fertility including, but not limited to fertility testing (except as otherwise covered and described within this summary of benefits and your EOC); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, artificial insemination (including test tube fertilization; the cost of donor sperm or eggs .... etc.