



state of breastfeeding coverage: health plan violations of the affordable care act



state of breastfeeding coverage:

health plan violations of the affordable care act

May 2015

Table of Contents

- Introduction 1
- The Affordable Care Act’s coverage of breastfeeding support and supplies..... 3
- Affordable Care Act requirements..... 4
 - Insurance plans must cover breastfeeding support and supplies, for the duration of breastfeeding 4
 - Insurance plans must provide access to out-of-network providers at no cost-sharing..... 4
 - Insurance companies may use limited “reasonable medical management” 4
 - Insurance companies can limit coverage to a manual pump..... 4
- Coverage problems that prevent women from getting breastfeeding benefits..... 5
 - Insurance companies impose unallowable limitations on breastfeeding support and supplies..... 5
 - Insurance companies have not established a network of providers and are not following federal rules allowing women to obtain services out-of-network, at no cost-sharing..... 6
 - Insurance companies impose major administrative barriers 7
 - Federal guidance allowing coverage of only manual pumps is insufficient 8
- Recommendations 9
- Conclusion 11

Introduction

THE AFFORDABLE CARE ACT'S (ACA) COVERAGE OF BREASTFEEDING EQUIPMENT, SUPPORT, AND COUNSELING IS A GROUNDBREAKING NEW INSURANCE BENEFIT.

In order to support women's efforts to breastfeed, and reduce cost barriers for women who want to breastfeed, the ACA requires insurance coverage of breastfeeding supplies, support, and counseling without co-payments, deductibles, or co-insurance.¹ This coverage is an important step to ensure women have the support and tools they need to breastfeed successfully.

However, some women do not fully benefit from this new coverage. In some cases, insurance policies fail to comply with the ACA's breastfeeding coverage requirements, or restrict coverage in ways that undermine the intent of the law.² In other instances, the federal guidance detailing coverage standards falls short of what women need to breastfeed successfully. Insurance plan noncompliance—and the lack of clear federal standards and inadequate guidance—means that women are not getting insurance coverage that meets their needs.

The National Women's Law Center (the Center) operates a nationwide hotline, CoverHer, which women can call when they face problems accessing the breastfeeding benefits to which they are entitled. Through this hotline, the Center has heard from women across the country. Women who contact the Center report spending hours on the phone with their insurance company trying to decipher what their insurance plan covers, and how they can get breastfeeding benefits as soon as possible. But, customer service representatives frequently give them conflicting information about their coverage, or wrongly tell them their plan does not provide coverage of breastfeeding support. Some women pay hundreds of dollars out-of-pocket for services; other women who cannot afford to pay the full cost of services forgo getting breastfeeding help altogether.

In addition to reports received through CoverHer, the Center reviewed over 100 plan documents from issuers in the new marketplaces in 15 states.³ This research, combined with stories from the hotline, points to three major trends that prevent women from getting breastfeeding benefits as required by law:

- Some insurance companies impose restrictions and limitations on breastfeeding support and supplies that explicitly violate the ACA or undermine the intent of the law;
- Some insurance companies do not have a network of lactation providers and are not following clear federal rules that allow women to obtain preventive services, including breastfeeding benefits, out-of-network, at no cost-sharing; and
- Some insurance companies impose major administrative barriers or offer insufficient coverage that prevents women from obtaining timely breastfeeding support and adequate equipment, as the ACA intended.

In addition to these three major trends, research and CoverHer contacts have reported other problems with the implementation of the ACA's breastfeeding benefit, such as plans limiting coverage to a manual pump, which is permitted by federal guidance but is a huge barrier to some women breastfeeding successfully.

This report highlights the obstacles women face when trying to get coverage for breastfeeding benefits and identifies strategies to remedy violations of the law and to revisit the insufficient federal guidance that leaves women without the coverage they need. To that end, the Center's recommendations call for insurance companies to come into compliance and correct any violations of the ACA. The recommendations also call for state and federal regulators to carefully review coverage policies and promptly respond to consumer complaints. And in order to ensure that federal

guidance itself does not permit insurance company policies that leave women with inadequate breastfeeding coverage, the recommendations call for the Departments of Health and Human Services, Treasury, and Labor (the Departments) to engage a range of stakeholders to reexamine coverage standards and develop new guidance that ensures women across the country get the tools they need to breastfeed successfully.

The Affordable Care Act's coverage of breastfeeding support and supplies

THE ACA'S BREASTFEEDING BENEFITS ARE PART OF THE LAW'S PREVENTIVE HEALTH SERVICES COVERAGE PROVISION, which is designed to enable individuals to avoid preventable conditions and improve health overall by increasing access to preventive care and screenings. This provision requires health insurance plans to provide coverage for certain preventive services without out-of-pocket costs, including a set of preventive services for women.

To determine which women's preventive services would be covered without out-of-pocket costs, the Health Resources Services Administration (HRSA) of the Department of Health and Human Services commissioned the Institute of Medicine (IOM) to study gaps in coverage of women's preventive services and to recommend which additional women's preventive services should be included. After conducting its analysis, the IOM recommended eight additional preventive services for women, including breastfeeding support and supplies. HRSA adopted the recommendations set forth in the IOM's report.⁴ According to the HRSA requirement, coverage is for comprehensive lactation support and counseling, including the costs of breastfeeding equipment, to ensure the successful initiation and continuation of breastfeeding.

The reason the IOM recommended adding coverage for breastfeeding support and supplies is because research has consistently shown that breastfeeding benefits the mother and the child. According to the Agency for Healthcare Research and Quality (AHRQ), breastfeeding reduces children's risk for a variety of common childhood illnesses and less frequent but serious conditions,

including sudden infant death syndrome, ear infections, upper and lower respiratory disease, asthma, childhood leukemia, childhood obesity, and Type 2 diabetes.⁵ It also reduces maternal risk for breast and ovarian cancer.⁶ Based on this and other research, the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics support exclusive breastfeeding for approximately six months, with continuation of breastfeeding, if possible, even longer.⁷

Despite the proven benefits of breastfeeding, there is a gap between women's decision to breastfeed their children and the support they need to successfully breastfeed for as long as intended. A majority of pregnant women plan to breastfeed and initiate breastfeeding at birth, but a much lower proportion of women continue to breastfeed. One study found that 76 percent of new mothers began breastfeeding, with 47 percent continuing to breastfeed at 6 months, and only 26 percent breastfeeding at 12 months.⁸ While breastfeeding rates have been growing steadily, there are significant gaps across racial, ethnic, and socioeconomic lines.⁹

The Surgeon General's Call to Action to Support Breastfeeding outlines several key barriers women face when breastfeeding. The report indicates that successful initiation of breastfeeding not only depends on experiences in the hospital but also depends on access to instruction on lactation from breastfeeding experts, particularly in the postpartum period.¹⁰

Affordable Care Act requirements

THE ACA REQUIRES HEALTH PLANS TO COVER BREASTFEEDING SUPPORT AND SUPPLIES WITHOUT CO-PAYMENTS, DEDUCTIBLES, OR CO-INSURANCE, FOR THE DURATION OF BREASTFEEDING.¹¹

The ACA requires this coverage for most employer health insurance plans, individual health coverage purchased on insurance Marketplaces operating in each state, and Medicaid enrollees who are newly eligible as part of a state's decision to adopt the ACA's Medicaid expansion.¹²

INSURANCE PLANS MUST COVER BREASTFEEDING SUPPORT AND SUPPLIES, FOR THE DURATION OF BREASTFEEDING

According to the HRSA recommendations, insurance plans must cover comprehensive lactation support and counseling by a trained provider, and costs of breastfeeding equipment. This requirement applies in conjunction with each birth. Federal guidance specifies that coverage for breastfeeding support and supplies extends for the duration of breastfeeding.¹³ This means that plans cannot impose time limits on when women can obtain lactation counseling and breastfeeding equipment.

INSURANCE PLANS MUST PROVIDE ACCESS TO OUT-OF-NETWORK PROVIDERS AT NO COST-SHARING

Federal guidance specifies that women must be able to obtain recommended preventive services with no cost-sharing, and, in some circumstances, obtain these services from out-of-network providers. Specifically, the guidance states, "if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the

item or service" (emphasis added).¹⁴ This means that if an insurance company does not have a network of providers for women to receive lactation counseling, then the plan must allow them to obtain lactation counseling from an out-of-network provider, at no cost-sharing.

INSURANCE COMPANIES MAY USE LIMITED "REASONABLE MEDICAL MANAGEMENT"

Under the regulations implementing the preventive health services, insurance companies are allowed to use "reasonable medical management techniques" to determine the "frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline."¹⁵ But these medical management techniques are not unlimited. While plans may use reasonable medical management techniques, they cannot limit or restrict coverage in ways that conflict with federal guidance. For example, because coverage of breastfeeding benefits extends for the duration of breastfeeding, plans cannot impose an arbitrary time limit on when women can access these benefits.

INSURANCE COMPANIES CAN LIMIT COVERAGE TO A MANUAL PUMP

Unfortunately, the Department of Health and Human Services has clarified that the ACA does not require insurance plans to cover a certain type of pump.¹⁶ However, a manual pump is insufficient for many women such as women returning to work, women who have preterm or ill infants, low milk supply, or women who have physical disabilities.¹⁷

Coverage problems that prevent women from getting breastfeeding benefits

UNFORTUNATELY, NOT EVERY WOMAN WHO SHOULD BE GETTING COVERAGE OF BREASTFEEDING SUPPORT AND SUPPLIES WITHOUT COST-SHARING HAS BEEN ABLE TO ACCESS THIS IMPORTANT BENEFIT.

The Center has documented this through the review of coverage policies in 15 states' marketplaces. In addition, the Center receives calls and emails through a nationwide hotline from women who face significant barriers to getting coverage to which they are entitled under the ACA.

The Center has identified three major trends that prevent women from getting breastfeeding benefits:

- Some insurance companies impose restrictions and limitations on breastfeeding support and supplies, which explicitly violate the ACA or undermine the intent of the law;
- Some insurance companies do not have a network of providers for women to get lactation counseling and are not following clear federal rules that allow women to obtain preventive services, including breastfeeding benefits, out-of-network, at no cost-sharing; and
- Some insurance companies impose major administrative barriers or offer insufficient coverage that prevents women from obtaining timely breastfeeding support and adequate equipment, as envisioned by the ACA.

INSURANCE COMPANIES IMPOSE UNALLOWABLE LIMITATIONS ON BREASTFEEDING SUPPORT AND SUPPLIES

Insurance companies have coverage policies for breastfeeding that are more limited than federal guidance allows. Women who have contacted the Center report that they had to obtain a breast pump within 6 months

after their baby was born. In some cases, women report the insurance company only covers a breast pump 48 days after delivery.

In addition to reports from women trying to use this benefit, the Center's plan document research found similar restrictions. Three health issuers in two states only allow women to obtain a breast pump within 6 months of delivery.¹⁸ Two issuers in one state limit rental of a breast pump to 12 months.¹⁹ Two issuers in two states indicate the plan determines the duration of rental.²⁰ One issuer limits coverage of a breast pump to one purchase every three years.²¹ All of these restrictions are clear violations of the ACA's requirement to provide coverage for the duration of breastfeeding.²²

Many women need access to breast pumps to maintain their milk supply, particularly when returning to work. In fact, one of the reasons the IOM recommended coverage of breastfeeding equipment was to ensure that women who return to work or have other obligations that separate them from their infant can continue to breastfeed, if they choose to, without cost barriers.²³

Several hotline callers report similar limitations on breastfeeding support and lactation counseling. Women report that their insurance plan will only provide coverage for lactation counseling on an inpatient basis during the post-delivery hospital stay. If they are already home and having problems breastfeeding, their insurance plan says that lactation counseling is not covered.

In addition to reports from women facing barriers in accessing lactation counseling, the Center's plan document research found similar restrictions in lactation counseling. Six health insurance issuers in one state only allow women

to get lactation services within two months of delivery.²⁴ Three issuers in one state limit coverage to a single lactation visit within two months of delivery.²⁵ One company limits breastfeeding education to one visit per pregnancy.²⁶ Another company limits breastfeeding education to two services per calendar year (for pregnant women) and three counseling sessions in conjunction with each birth.²⁷ All of these examples conflict with federal guidance requiring insurance companies to cover breastfeeding equipment and support, in conjunction with each birth, for the duration of breastfeeding.²⁸

Some women need intensive lactation support to manage initial breastfeeding challenges such as insufficient milk supply or a newborn's difficulty latching. Sometimes a woman will need lactation support after breastfeeding has been established, if she encounters medical issues associated with breastfeeding, such as thrush or mastitis that affect her ability to breastfeed. Even after breastfeeding is well-established, some women who return to work experience problems with their milk supply and may need additional lactation counseling to continue breastfeeding.

The HRSA guidelines recognize the various points at which women may need lactation support and breastfeeding equipment, and specifically recommend that benefits should encompass the initiation and duration of breastfeeding. In all of these examples, insurance companies are imposing benefit limits and restrictions that violate the law.

INSURANCE COMPANIES HAVE NOT ESTABLISHED A NETWORK OF PROVIDERS AND ARE NOT FOLLOWING FEDERAL RULES ALLOWING WOMEN TO OBTAIN SERVICES OUT-OF-NETWORK, AT NO COST-SHARING

Despite the ACA's requirement to provide "comprehensive lactation support," insurance companies have not established networks of lactation providers.²⁹ In these instances, the plan typically refers women to their obstetrician or to the child's pediatrician—neither of whom usually offers lactation counseling. In some cases, women report that insurance companies have *one* in-network lactation provider (usually located in a hospital) to serve all of the plan's enrollees. And in the case of hospital-based lactation consultants, hospital policy often restricts these providers to in-patient clients, which means women cannot access these health professionals once they are discharged from the hospital.

The lack of a provider network for lactation counseling means that women must turn to out-of-network providers to get help with breastfeeding. Federal guidance clearly allows women to obtain required preventive services, including breastfeeding benefits, through out-of-network providers, at no cost-sharing, when the plan does not maintain a network of appropriate providers.³⁰ However, dozens of women have contacted the Center to report their insurance company is ignoring this rule and denying payment for services they obtained out-of-network. These denials violate the ACA.

IN THEIR OWN WORDS: DENIED COVERAGE OF A BREAST PUMP

"I was going back to work and wanted to use a breast pump. My insurance company told me that I wasn't eligible for a breast pump because it had been over 180 days since I gave birth. I contacted the Center to see if this policy was correct. The Center helped me file a claim and later an appeal with my insurance company. Many months later they reimbursed me \$200 for a breast pump. The whole ordeal was such a hassle."

—Nicole, California

IN THEIR OWN WORDS: DENIED COVERAGE OF LACTATION COUNSELING

“My daughter was only a few days old, and had been so dehydrated at the hospital (due to breastfeeding issues) that they almost put her in the NICU. I needed to see a lactation specialist immediately, but my insurance company didn't have any lactation providers in their directory. So I called my insurance company to find out if I could get coverage. They told me that their in-network provider was La Leche League and gave me the names and numbers of two women who run a local La Leche League meeting. But when I contacted these women, they explained that La Leche League is a breastfeeding support group, not a provider network! I ultimately saw a certified lactation consultant on my own, which solved my breastfeeding problems. Now I'm trying to get reimbursed. I've been fighting with my insurance company since July 2014 and I'm still trying to get reimbursed!”

—Alysson, Washington DC

When plans fail to establish a network of providers, women face significant barriers to accessing breastfeeding benefits that should be covered by law. Women have to pay at the point of service for lactation counseling, and seek reimbursement from their plan afterwards. Plans often deny these claims because the woman obtained benefits out-of-network. Upon appeal, some plans will partially reimburse the cost of lactation counseling—but they reimburse at the out-of-network rate which means women still pay significant money for services that should have been fully covered. Women report that some plans deny the claim altogether because they did not follow a lengthy and time-consuming

administrative process to get approval from the plan to access out-of-network providers.³¹ These practices effectively shift more costs to women. Some women—especially women with limited income or who may be taking unpaid family leave—will not be able to pay the full cost of lactation counseling at the point of service, and will not get the care they need. For these women, they effectively have no benefit at all.

IN THEIR OWN WORDS: DENIED COVERAGE AND CAN'T AFFORD SERVICES

“I'm currently fighting with my insurance company to reimburse me for lactation counseling that I got right after my son was born. I tried to go in-network but the plan didn't have any in-network lactation consultants. I've already spent \$375 dollars. I'd like to see a lactation consultant again because I'm still having breastfeeding problems. I'm three weeks post-partum and feel like I'm running out of time to establish breastfeeding. But, the visits are so expensive and I'm not sure how much more I can spend out-of-pocket, especially while I'm on maternity leave.”

—A Woman in Virginia

INSURANCE COMPANIES IMPOSE MAJOR ADMINISTRATIVE BARRIERS

Insurance companies impose administrative barriers that hamper women's ability to get timely breastfeeding benefits. These barriers include medical management techniques like prior authorization and restrictions on when women can get services. For example, women report that some insurance companies will not provide coverage of a breast pump until after the baby is born and only after going through some administrative barriers such as getting a prescription or prior authorization.

Women in these plans will not get their breast pumps until a few weeks after they give birth. This coverage policy is problematic because some women need a breast pump immediately. The newborn could be unable to latch properly, or need intensive medical services that require them to be admitted into the Neonatal Intensive Care Unit (NICU). Premature babies or newborns with other health challenges may have difficulty feeding and women will need to begin using a breast pump immediately to establish their milk supply.

In other instances, some women who previously faced breastfeeding challenges and are having subsequent children may already know they need to use a breast pump shortly after giving birth to help build their milk supply. Coverage policies that limit when a woman can get a breast pump can interfere with her attempts to initiate breastfeeding. Further, the IOM's recommendation is for comprehensive support "in conjunction with each birth." Nothing in the ACA or federal guidance indicates that the coverage only begins after delivery.

FEDERAL GUIDANCE ALLOWING COVERAGE OF ONLY MANUAL PUMPS IS INSUFFICIENT

Unfortunately, the Department of Health and Human Services indicates that, under the ACA, insurance plans are not required to cover a certain type of pump.³²

For example, some plans only provide coverage of a manual pump and exclude all electronic or hospital grade pumps. Limiting coverage to a manual pump means that some women will not get access to the tools they need to successfully breastfeed.

Women need access to hospital grade pumps for various reasons. Women who have newborns in the NICU and are separated from their infant cannot initiate breastfeeding with a manual pump. Women in these circumstances will require an electric or hospital grade pump to establish their milk supply.³³ The American Academy of Pediatrics (AAP) strongly encourages feeding infants who are in the NICU human milk.³⁴

Further, AAP recommends that breast pump coverage include all grades of breast pumps (manual, electric, hospital grade), indicating that "[m]anual breast pumps may not be appropriate in all situations and benefit plans should include coverage for electric and hospital grade breast pumps. Double electric or hospital grade pumps are often more efficient to maintain milk supply for mothers that return to work."³⁵ In addition, women returning to work may find a manual pump incompatible with their need to express milk quickly and efficiently during the work day.

IN THEIR OWN WORDS: WOMEN NEED BETTER COVERAGE

Debbie is a Clinical Nurse Specialist and International Board Certified Lactation Consultant. In her level 4 NICU, she works with new mothers who are separated from their infants and require a hospital grade breast pump to establish their milk supplies and feed their babies.

"Providing a manual or consumer level pump to a mother who has a newborn in the NICU is totally insufficient. These mothers need a hospital grade pump, and lots of lactation support."

—Debbie, Clinical Nurse III/IBCLC

Recommendations

THE ACA'S BREASTFEEDING BENEFITS ARE A HUGE STEP FORWARD that can remove the cost barriers associated with breastfeeding support and equipment and give women the tools they need to successfully breastfeed for as long as they want. However, because insurance companies are not following the law, women are not getting breastfeeding benefits as required by the ACA. To make certain that every woman gets the coverage guaranteed to her under the ACA, insurance companies and state and federal governments must take steps to ensure plans comply with the law.

INSURANCE COMPANIES: BRING COVERAGE INTO COMPLIANCE

- Insurance companies **must carefully examine coverage documents to ensure the policy complies** with federal regulation and guidance. Plans should immediately remove restrictions or limitations that violate the ACA.
- Insurance companies **must—at a minimum—establish a network of lactation providers** so women can obtain timely in-network lactation services with no cost-sharing or up-front costs, within a reasonable distance. As plans build this network, however, they must allow women to obtain services from out-of-network providers, at no cost-sharing, as required by law.
- Insurance companies **must remove all administrative barriers to getting timely lactation support.** Women should not be required to pay the full costs of lactation counseling out-of-pocket and then seek reimbursement through a series of claims and appeals.
- Insurance companies **must remove all administrative barriers to getting a breast pump.** Insurance companies should permit women to obtain breast pumps prior to delivery. They should also have an expedited process so that women can acquire a breast pump quickly when they need it.

FEDERAL AND STATE REGULATORS: ENFORCE THE LAW

- Federal regulators must **ensure plans comply with the ACA's breastfeeding benefits and enforce the law.** It is inexcusable to expect women to pay the full costs of lactation services, up-front, with no guarantee the costs will be fully reimbursed, as required by law. It is also inexcusable to allow insurance companies to circumvent reasonable network requirements.
- State regulators **must ensure health insurance complies with the ACA,** its implementing regulations, and related guidance. Most states are responsible for the initial certification of health plans on state and federal Marketplaces. State regulators must be diligent in their review of Qualified Health Plan documents and determined in their efforts to bring plans into compliance with the law during the certification process.
- State regulators **must be diligent about responding to complaints** about coverage violations. State regulators must respond to complaints from women about insurance practices that create administrative barriers to required coverage. Regulators should pay particular attention to complaints of an insufficient network for lactation counseling.
- State regulators should **inform women about the law** and its coverage requirements for women's health. For example, states should work with stakeholders to develop and distribute informational bulletins on the ACA's preventive services requirements and the scope of breastfeeding coverage. Women need this information to be informed consumers and to advocate for the coverage they need.

- ✓ State regulators should **broadly publicize the appeals process**. Women need to know the appropriate course of action when plans fail to provide the coverage the ACA requires, and plans need to be held accountable when they do not comply with the law.

Compliance with the existing law is not enough. To fulfill the promise of this benefit, policymakers need to reexamine what coverage should encompass, and should more closely align coverage requirements with the IOM's recommendations and input from a range of important stakeholders

THE DEPARTMENTS OF HEALTH AND HUMAN SERVICES, TREASURY, AND LABOR: REVISIT GUIDANCE AND ENGAGE STAKEHOLDERS

- ✓ The Departments **should revisit current guidance** to ensure coverage of breastfeeding support and supplies aligns with the Institute of Medicine's recommendations and best practices.
- ✓ The Departments **should engage stakeholders**—breastfeeding experts, the medical community, advocates, and insurance companies—**to develop new federal standards** for breastfeeding coverage that takes into account the best evidence.

Conclusion

THE ACA'S INVESTMENT IN PREVENTIVE SERVICES AND BREASTFEEDING BENEFITS IS A HISTORIC STEP FORWARD. Access to breastfeeding equipment and the expertise of trained lactation providers is critical to removing barriers to breastfeeding. Millions of women across the country are already benefitting from the law, in terms of both their health and the impact it has on their families and lives. But, there is significant room for improvement—right now, women do not have access to coverage required by law and face inexcusable barriers to getting breastfeeding benefits. All stakeholders must work together to correct these problems and ensure that breastfeeding benefits fulfill the promise of the ACA.

Endnotes

- 1 The Affordable Care Act defines “cost-sharing” to include “deductibles, coinsurance, copayments, or similar charges.” (42 U.S.C. § 18022(c)(3)(A)(i).)
- 2 This report uses the term “insurance companies” throughout to refer to both group and individual health plans.
- 3 The analysis encompasses more than 100 publicly available certificates of coverage for Qualified Health Plans offered in 2014 and/or 2015 from Alabama, California, Colorado, Connecticut, Florida, Maine, Maryland, Minnesota, Nevada, Ohio, Rhode Island, South Dakota, Tennessee, Washington, and Wisconsin.
- 4 U.S. Dep’t of Health and Human Svcs., Health Res. and Svcs. Admin., *Women’s Preventive Services Guidelines* (Aug. 1, 2011), Accessed at <http://www.hrsa.gov/womensguidelines/>
- 5 Ip S, Chung M, Raman G, Chew P, Magula N, DeVine D, Trikalinos T, Lau J. Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries. Evidence Report/Technology Assessment No. 153 (Prepared by Tufts-New England Medical Center Evidence-based Practice Center, under Contract No. 290-02-0022). AHRQ Publication No. 07-E007. Rockville, MD: Agency for Healthcare Research and Quality. April 2007.
- 6 Ibid.
- 7 Institute of Medicine, “Clinical Preventive Services for Women: Closing the Gaps,” (2011), the National Academies Press.
- 8 CDC National Immunization Surveys 2012 and 2013, Data, 2011 births. Accessed at http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm.
- 9 The Surgeon General’s Call to Action to Support Breastfeeding. Office of the Surgeon General (US); Centers for Disease Control and Prevention (US); Office on Women’s Health (US). Rockville (MD): Office of the Surgeon General (US); 2011.
- 10 Office of the Surgeon General (US); Centers for Disease Control and Prevention (US); Office on Women’s Health (US). Rockville (MD): Office of the Surgeon General (US); 2011. Accessed at <http://www.ncbi.nlm.nih.gov/books/NBK52688/>.
- 11 The ACA’s preventive services benefits, including breastfeeding support and supplies, are implemented through regulations at 45 CFR 147.130 and federal guidance from the United States Department of Health and Human Services, Department of Labor, and Treasury Department FAQs about Affordable Care Act Implementation (Part XII). These rules apply to most employer plans and to women newly eligible for Medicaid.
- 12 While traditional Medicaid programs cover a wide range of preventive services for Medicaid enrollees with nominal or no co-payments, they are not required to provide this benefit under the ACA. This means that traditional Medicaid programs, including pregnancy-related coverage, are not required to provide breastfeeding support and supplies but many states choose to provide these benefits. Based on a 2012 survey with 44 states responding, 25 states covered breastfeeding education services, 15 states covered individual lactation consultations, and 31 states covered equipment rentals.
- 13 United States Department of Labor, “FAQs About Affordable Care Act Implementation (Part XII),” (February 20, 2013) Accessed at <http://www.dol.gov/ebsa/faqs/faq-aca12.html>.
- 14 Ibid.
- 15 45 C.F.R. 147.130 (2014).
- 16 United States Department of Health and Human Services, Breast Pumps and Insurance Coverage: What You Need To Know, updated September 2014. Accessed at <http://www.hhs.gov/healthcare/prevention/breast-pumps/index.html>.
- 17 The Center has talked to a lactation consultant in Virginia who has a client with significant arthritis in her hands who is unable to operate a manual breast pump.
- 18 Kaiser Permanente, offered in Colorado (2014 & 2015); BlueCross Blue Shield of MN, offered in Minnesota (2014).
- 19 Kaiser Permanente, offered in Ohio (2014); HealthSpan, offered in Ohio (2015).
- 20 UnitedHealthcare, offered in Connecticut (2015); UnitedHealthcare, offered in Ohio (2015).
- 21 Aetna, offered in Ohio (2015).
- 22 United States Department of Labor, “FAQs About Affordable Care Act Implementation (Part XII),” (February 20, 2013) accessed at <http://www.dol.gov/ebsa/faqs/faq-aca12.html>.
- 23 Institute of Medicine, “Clinical Preventive Services for Women: Closing the Gaps,” (2011), the National Academies Press.
- 24 Anthem BlueCross BlueShield of Connecticut and Anthem BlueCross BlueShield Multi-State Plan, offered in Connecticut (2014 & 2015); Healthy CT, offered in Connecticut (2014 & 2015); Healthy CT Multi-State Plan, offered in Connecticut (2015).
- 25 Anthem BlueCross BlueShield and Anthem BlueCross BlueShield Multi-State Plan, offer in Connecticut (2014 & 2015).
- 26 BlueCross BlueShield of Tennessee offered in Tennessee (2014).
- 27 BlueCross Blue Shield of Alabama, offered in Alabama (2015).
- 28 United States Department of Labor, “FAQs About Affordable Care Act Implementation (Part XII),” (February 20, 2013) Accessed at <http://www.dol.gov/ebsa/faqs/faq-aca12.html>.

- 29 Hotline callers report coverage problems with CareFirst, UnitedHealthcare, and several BlueCross Blue Shield companies.
- 30 United States Department of Labor, "FAQs About Affordable Care Act Implementation (Part XII)," (February 20, 2013) accessed at <http://www.dol.gov/ebsa/faqs/faq-aca12.html>.
- 31 Hotline callers report that some plans require them to get a "gap exception" to access out-of-network providers. Women report that when they tried to obtain a gap exception, the approval process took over three weeks.
- 32 United States Department of Health and Human Services, Breast Pumps and Insurance Coverage: What You Need To Know, updated September 2014 Accessed at <http://www.hhs.gov/healthcare/prevention/breast-pumps/index.html>.
- 33 Based on information from the hotline, some insurance companies provide coverage of a hospital grade pump after getting a prescription or similar documentation from their doctor or healthcare provider.
- 34 American Academy of Pediatrics, Section on Breastfeeding, Breastfeeding and the Use of Human Milk. Pediatrics Vol. 129 No. 3 March 1, 2012 pp. e827-e841. Accessed at <http://pediatrics.aappublications.org/content/129/3/e827.full?sid=ee79f8ed-6856-4f36-9ef2-d83a88178219>.
- 35 American Academy of Pediatrics, Letter to Payers, October 2013. Accessed at <http://www2.aap.org/breastfeeding/files/pdf/McInernyLettertoPayers-BreastPumps.pdf>.



11 Dupont Circle, Suite 800
Washington, DC 20036
202.588.5180 | fax 202.588.5185
www.nwlc.org

