Health law targets women's preventive services, but it offers help to men, too

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This week, I answered a couple of questions from readers about preventive health benefits and looked into coverage options for people who travel frequently.

Q: Why aren't there preventive health recommendations for men like there are for women under the health law? Women and breast cancer get so much attention by the health care community. Heart health, diabetes, prostate cancer and colon cancer are a few examples of opportunities for education and preventive screening for men.

There are many recommendations for men's preventive care in the health law, although most of the examples you mention apply to women as well. Under the law, services recommended by the U.S. Preventive Services Task Force have to be provided without charging people anything out of pocket. The independent panel of medical experts currently recommends that women and men be screened for high blood pressure, elevated cholesterol and blood sugar levels, and for colorectal cancer. It advises against routinely screening men for prostate cancer, however, noting that research hasn't shown it reduces death from the disease. (Medicare covers an annual prostate cancer test, but you may owe a copayment.)

The drafters of the health law paid special attention to women's preventive health needs, creating additional recommendations targeted specifically at them. This was done in part to address recognized gaps in women's services, especially in the areas of sexual and reproductive health, said Adam Sonfield, senior policy manager at the Guttmacher

Institute, a reproductive health research and policy organization.

The federal government is in the process of updating the women's preventive health guidelines. If it adopts the working group recommendations this fall, insurers will begin to cover condoms and vasectomies for men without charge. Adding this no-cost benefit would address an inequity in current coverage rules and help both women and men avoid unwanted pregnancies.

Q: I am 74 years old and on Medicare. My mother died of ovarian cancer and two maternal aunts and my paternal grandmother had breast cancer. Does Medicare cover BRCA testing?

Medicare generally only covers genetic testing for the two BRCA mutations that are associated with an increased risk of breast and ovarian cancer if you've already been diagnosed with cancer and have a family history that indicates testing is appropriate.

Throughout its history, the Medicare program, which provides health benefits for older and disabled Americans, has focused on treating injury and illness, not preventing them. Although the program now covers some cancer screening tests such as mammograms and colonoscopies, those changes were specifically authorized by Congress.

It's a wrongheaded approach, said Dr. J. Leonard Lichtenfeld, deputy chief medical officer at the American Cancer Society. "I'm incensed that this is not covered," he said.

The BRCA test results could be important not only to the woman but also to her siblings and children, Lichtenfeld said.

The U.S. Preventive Services Task Force recommends that women who have a family history of breast or ovarian cancers be screened to

determine if they're at higher risk for potentially harmful genetic mutations and, if appropriate, referred for genetic counseling and BRCA testing. Under the health law, private insurers are required to cover such testing without charging women for it. But that provision does not apply to Medicare.

There are non-insurance options for testing, Lichtenfeld noted. Color Genomics, for example, offers a genetic test that analyzes 30 genes associated with hereditary cancers, including BRCA 1 and BRCA 2, for $249.

Q: Are there any options available for people with marketplace plans who travel regularly? Emergency costs for an accident should be covered, but what about follow-up care after an accident or an illness while traveling? How does this work with increasingly narrow provider networks?

The situation you describe can be tough to manage. Under the health law , an insurer can't require you to pay more for care in an emergency department that's not in your provider network than it would have mandated for emergency care in network.

But once you leave the emergency department, you may get hit with out-of-network charges if you're admitted to the hospital, for example, or need other follow-up care and are far from home.

You have a few options. Individual Blue Cross Blue Shield plans that are sold on many marketplaces may offer access to BCBS providers nationwide and overseas.

Be sure to check with individual Blues plans before signing up if that type of coverage is important to you, said Paul Rooney, vice president of carrier relations at eHealth.com, an online insurance broker.

"Some of the local Blues are pulling [that coverage] from their offerings," he said.

You might consider buying an accident policy. These plans typically pay a fixed dollar amount to offset your costs if you're injured in an accident. But they can be tricky, said Nate Purpura, vice president of consumer affairs at eHealth.com. The policies don't cover pre-existing medical conditions, and the insurer might deny a claim that it considers related to an earlier medical problem, he said.