

state of **women's** coverage: health plan violations of the affordable care act

ABOUT THE CENTER

The National Women's Law Center is a non-profit organization that has been working since 1972 to advance and protect women's equality and opportunity. The Center focuses on major policy areas of importance to women and their families, including economic security, education, employment and health, with special attention given to the concerns of low-income women.

For more information about the Center or to make a tax-deductible contribution to support the Center's work, please visit: www.nwlc.org or call the Development office at 202-588-5180.

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DISCLAIMER

While text and citations are, to the best of the authors' knowledge, current as this report was prepared, there may be subsequent developments—including changes to the plan documents or new administrative guidance—that could alter the information provided herein.

This report does not consist of an exhaustive list of violations in health plans and is not meant to be used to inform consumers about their personal health coverage. In addition, this report does not constitute legal advice; individuals and organizations considering legal action should consult with their own legal counsel before deciding on a course of action.



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Introduction

THE AFFORDABLE CARE ACT (ACA) MAKES DRAMATIC IMPROVEMENTS FOR WOMEN'S HEALTH COVERAGE AND WOMEN'S HEALTH CARE by ending discriminatory health insurance practices, making health coverage more affordable and easier to obtain, and improving coverage for the essential health services women need.¹ Among other reforms, the law creates new Health Insurance Marketplaces, which operate in every state, where women can compare Qualified Health Plans (QHPs) and shop for affordable, comprehensive health coverage for themselves and their families. During the 2015 open enrollment period, nearly 6.3 million women purchased coverage from QHPs.²

As a result of this important law, pregnant women have coverage for prenatal care, labor and delivery, and postpartum care; women with chronic illnesses are able to manage their condition with coverage for prescription drugs, ambulatory care, and chronic disease management; women of reproductive age have comprehensive access to birth control that enables them to determine when and whether they become pregnant; and all women have access to a range of preventive services without the financial burden of cost-sharing to ensure they live longer, healthier lives.

This report examines how health plans have responded to these historic changes. More specifically, the analysis focuses on coverage options available to women on Marketplaces by studying issuers' coverage documents to determine whether or not Marketplace plans are covering women's preventive services, maternity care, and other services critical to women's health as required by the ACA.

This analysis shows that the vast majority of health insurance issuers considered in this report offer coverage that violates specific requirements of the law (see Appendix A for number of violations in each state).

In addition, this analysis finds ACA violations with at least one issuer in every state included in this report, across a wide range of women's health concerns. Specifically, this analysis finds ACA violations related to maternity care, birth control, breastfeeding supports and supplies, genetic testing, well-woman visits, prescription drug coverage, care related to gender transition for transgender individuals, chronic pain treatment, and certain pre-existing conditions.

STATES INCLUDED IN THIS REPORT:

Alabama, California, Colorado, Connecticut,
Florida, Maine, Maryland, Minnesota, Nevada,
Ohio, Rhode Island, South Dakota,
Tennessee, Washington, and Wisconsin

Although this report examines issuers offering plans on a subsection of Marketplaces, the extent of these violations suggests that similar violations also pervade QHP documents in other states.

These violations leave women without the coverage they need and that is required by law. This means women could be forced to pay for care that their plan should cover, or go without needed health care altogether.

To realize the full promise the ACA offers for women's health, state regulators and issuers must identify and correct violations before plans are sold on the Marketplaces, or whenever problems are identified. Consumers should know their rights, and advocate for themselves. And advocates must work directly with consumers, issuers, and regulators to educate, identify problems, and correct violations. To that end, this report includes recommendations for issuers,

consumers, advocates, and state and federal regulators, all of whom must ensure that the promise of the ACA becomes a reality for women across the country. The report also provides examples of how the National Women's Law Center (the Center) and its partners have worked directly with issuers and key regulators to correct many of these violations.

Methodology

This report analyzes the certificates of coverage for health plans offered in 15 states in 2014 and 2015. In six states, the report considers issuers for both plan years, while in other states the report examines issuers for one plan year. In some cases plan documents—sometimes called the “certificate of coverage” or “evidence of coverage”—were not available for all issuers in a state. However, two years of analysis provides a broad range of issuers and plans for this analysis.

The analysis encompasses more than 100 publicly available certificates of coverage from Alabama, California, Colorado, Connecticut, Florida, Maine, Maryland, Minnesota, Nevada, Ohio, Rhode Island, South Dakota, Tennessee, Washington, and Wisconsin (see Appendix B for a list of issuers by state and year).³ The Center secured certificates of coverage through online searches and by working with state advocates across the country to access the documents. The states reflect a diverse sample in terms of geography, political environment, and use of a federal or state Marketplace.

This report highlights the violations that issuers included in their plans for both years. For the sake of readability, all findings are reported in present tense, although issuers may no longer offer some of the 2014 plans or may have corrected some of the 2014 violations. In cases where it is known an issuer or issuers have corrected these problems, there is a notation in the endnote. In each section, the report notes the number of issuers with violations. Issuers are counted separately for each year that a violation occurs. The endnotes include issuers' names, plan years, and states for each violation.

This analysis focuses on coverage areas of particular importance to women, including preventive services such as birth control, well-woman visits, and lactation supports; prenatal and maternity care; abortion services; and exclusion policies. It therefore does not address all possible ACA violations, or even all coverage limitations that women may face. Women experience a wide range of acute and chronic health issues, and issuers may limit coverage for these conditions in ways that this analysis does not capture.

In addition, this report relies on plan documents, not on medical management policies, formularies, benefit determinations, or other cost-containment strategies that also determine which services a plan covers. Moreover, as issuers, regulators, and advocates scrutinize plan documents, other violations may also become apparent. Additional problems with issuers' coverage policies are also likely to come to light as women use their coverage.

HOW ARE ISSUERS COUNTED IN THIS REPORT?

Issuers are counted separately for each year that a violation occurs. For example, the finding that eight issuers in Connecticut impermissibly restrict coverage for infertility services counts one issuer twice when an issuer included this violation in both 2014 and 2015 plan documents.

The ACA's key reforms for women

PRIOR TO THE ACA, INSURANCE COVERAGE ON THE INDIVIDUAL MARKET OFTEN FAILED WOMEN.

First, insurance companies could deny women coverage altogether, charge higher premiums or impose waiting periods based on their health history, and many plans charged women higher premiums simply for being women.⁴ Second, issuers frequently did not cover important women's health services, such as maternity care, prescription drugs, and lactation counseling. In fact, before the ACA, the vast majority of individual market plans did not cover maternity care at all, while a limited number of insurers sold separate maternity riders for an additional premium.⁵ Similarly, before the ACA took effect, 1.3 million Americans were enrolled in individual market plans that did not have prescription drug coverage.⁶

The ACA reformed the individual insurance market to ensure that plans sold on this market meet women's needs. Health insurance issuers must offer coverage to all applicants, regardless of whether they have a pre-existing condition, and can only vary premium prices based on geography, age, family size and, at state discretion, smoking status—not gender or health condition. The law also prohibits issuers from imposing a waiting period before covering a pre-existing condition.

The ACA requires all individual and small group market plans to cover Essential Health Benefits (EHB) such as maternity and newborn care, preventive and wellness services and chronic disease management, behavioral health services, and prescription drugs. By requiring plans in these markets to cover all of these benefits, the ACA corrects notable benefit gaps and significantly advances women's access to critical health services.

The ACA also created a historic opportunity to focus on disease prevention and early detection by requiring insurance companies to cover a wide range of preventive services, making these important services more affordable and accessible for millions of women.

Before implementation of the law, women were more likely than men to go without necessary health care, including preventive care, because of cost.⁷

Plans must now cover these services—typically screenings, immunizations, patient education, and other proven preventive care—without cost-sharing, thus removing financial barriers to care and allowing women to stay healthy and address problems before they become untreatable. The law also requires that all new health plans cover a number of preventive services specific to women, including the full range of FDA-approved birth control methods, sterilization, and related education and counseling, well-woman visits, screening for gestational diabetes, breastfeeding support, supplies, and counseling, and domestic violence screening and counseling. These services, which plans must cover without cost-sharing, help women manage key aspects of their lives, such as determining when and if they become pregnant, recognizing and addressing unhealthy relationships, and ensuring healthy pregnancies and thriving newborns.

The ACA and its regulations prohibit discrimination in nearly all parts of the health care system. Section 1557 of the ACA protects individuals from discrimination based on race, color, national origin, sex, sex stereotypes, gender identity, age, or disability in health programs or activities operated by recipients of federal financial assistance; federally-administered programs or activities; or entities created under the ACA. Section 1557 is the first federal statutory protection that broadly prohibits sex discrimination in health care and applies to virtually all aspects of the health care system.

The ACA's reforms are historic for women's health. In order to ensure women are benefiting from the important reforms outlined here, issuers must comply with the ACA. Only through complete plan compliance can women be sure they are provided the full benefits and protections of the ACA.

Violations of the Affordable Care Act

MATERNITY COVERAGE THAT FAILS TO COMPLY WITH THE ACA

FOURTEEN ISSUERS ACROSS SEVEN STATES OFFER MATERNITY COVERAGE THAT DOES NOT COMPLY WITH THE ACA.

Violations of maternity coverage requirements include:

- Excluding maternity coverage for dependent enrollees
- Restricting pregnant women's access to maternity services outside of the plan's service area
- Establishing arbitrary limits on maternity benefits, such as a single ultrasound

Fourteen issuers across seven states offer maternity coverage that does not comply with the ACA.

To correct longstanding gaps in women's access to maternity coverage, the ACA requires all qualified health plans to cover maternity and newborn care as an essential health benefit. Before the ACA, the vast majority of individual market plans did not cover maternity care at all, while a limited number of insurers sold separate maternity coverage for an additional fee.⁸ The high cost of maternity services was a major obstacle to women seeking critical prenatal care, which is proven to improve newborns' health outcomes.⁹

All QHPs must cover maternity care as part of the ten categories of Essential Health Benefits, and must extend this coverage to all enrollees, regardless of their status as dependents or spouses. The scope of maternity and newborn coverage can vary slightly by issuer and state, but a benchmark plan for each state sets the standard

ACA PROVISIONS ON MATERNITY COVERAGE

Maternity and newborn care is one of ten Essential Health Benefits. All qualified health plans are required to provide this coverage to all enrollees.

Key regulations:

The Essential Health Benefits are implemented through 45 CFR 156.115. Of special note for maternity coverage:

- Dependent enrollees cannot be excluded from maternity coverage.
- All qualified health plans must be substantially equal to the state's benchmark plan, meaning that plans cannot create new exclusions and limitations that were not approved as part of the selection of the state's benchmark.

The ACA also created new protections for women who need emergency coverage away from home or outside their plan's network. The implementing regulations at 45 CFR 147.138 state that:

- Issuers must cover emergency services whether or not the provider is part of the plan network and without imposing coverage limits or other requirements that are "more restrictive" than the plan's coverage of emergency services delivered by in-network providers.

This is an important protection for all enrollees, but of particular importance to pregnant woman who may need emergency maternity coverage when away from home.

for coverage, meaning that states cannot create limits or exclusions on maternity care that go beyond the state's benchmark.

Violations of the requirements to provide maternity and newborn care pose serious threats to women and newborns. Early prenatal care is an essential element of good pregnancy care. While the United States has made progress on maternal and newborn health outcomes, infant mortality and preterm birth rates remain higher than in other developed countries.¹⁰ Prenatal care helps providers identify and manage problems that can emerge throughout pregnancy and to mitigate risks associated with underlying chronic disease. Women who have little or no prenatal care are at increased risk for preterm labor, which is a leading factor in infant mortality and adverse health outcomes.¹¹

Excluding Dependents from Maternity Coverage

Two issuers in two states exclude dependent enrollees from maternity coverage. A Tennessee insurance issuer explicitly excludes maternity coverage for dependent enrollees, stating that maternity expenses for dependents are excluded from coverage “unless there are life-threatening complications.”¹² An issuer in Ohio had similar language that suggested dependents could be excluded from coverage by limiting maternity coverage to “the member or member’s spouse.”¹³ Regulations defining the Essential Health Benefits, of which maternity care is one, clearly state that a plan cannot exclude an

enrollee from any required coverage category.¹⁴

Dependents can include spouses, domestic partners, and children under 26, which means that pregnant women who are covered as a dependent under a range of family relationships would not have insurance coverage for their pregnancy in this plan.

As a result of excluding dependent enrollees from maternity care, a pregnant woman could miss important prenatal screenings, ultrasounds, and regular check-ups throughout her pregnancy. She would also be expected to pay out-of-pocket for services she receives, as well as for her labor and delivery. The significant cost of pregnancy care would put her and her family at real financial risk, while missing important health services throughout her pregnancy could also threaten her health and the health of her newborn.

Impermissibly Limiting Maternity Benefits

Five issuers in three states create impermissible limits on maternity benefits. An issuer in Colorado and an issuer in South Dakota both limit the number of ultrasounds a pregnant woman can receive.¹⁵ One issuer limits a woman to a single ultrasound and the other issuer only covers two routine ultrasounds. An issuer in Alabama limits the number of prenatal visits to six per year.¹⁶ Three Colorado issuers impermissibly limit the scope of maternity coverage by excluding “preconception counseling, paternity testing, genetic testing, or testing for inherited disorders, screening for disorders, discussion of family history...”¹⁷

WORKING TOWARDS BETTER COVERAGE EXCLUDING DEPENDENTS FROM MATERNITY CARE

In 2014, Buckeye Community Health in Ohio stipulated that a pregnant woman who is enrolled as a dependent in her plan would not be covered for maternity care. This is an egregious violation of the ACA that leaves women without access to care at such a critical time. The Center worked with advocates at Innovation Ohio to approach Buckeye Community Health about this violation.

The issuer responded that they would correct the violation in the plan documents to make clear that dependent enrollees are covered for maternity care. This is a significant achievement for women in this plan, who can now be assured that they have coverage for maternity services whether or not they are enrolled as a dependent.

A Wisconsin issuer impermissibly limits the services a pregnant woman can receive based on her age.¹⁸

These limitations violate the state's EHB-benchmark plan, which establishes the coverage parameters for the ten categories of EHB in each state. According to the federal rules implementing EHB, issuers must provide benefits that are "substantially equal" to the state's EHB-benchmark plan, including covered benefits and limitations.¹⁹ However, in these cases, the issuers do not meet the maternity coverage requirements of the state EHB-benchmarks. The EHB-benchmark plans in Colorado, South Dakota, and Alabama do not include quantitative limits on ultrasounds or prenatal visits. In addition, the Colorado EHB-benchmark plan does not limit the scope of maternity coverage by excluding key counseling services and screenings, nor does the Wisconsin EHB-benchmark plan include an age limit for certain prenatal services.^{20, 21}

These exclusions could result in fewer opportunities to receive important prenatal screenings or identify complications that can arise during pregnancy—and to intervene as early as possible to improve health outcomes for the woman and her newborn.

Limiting Women's Access to Maternity Care Outside of the Service Area

Six issuers across three states exclude coverage of maternity care or services related to labor and delivery outside the plan's service area. Depending on the issuer, these exclusions cover the duration of pregnancy, the final trimester of pregnancy, or the final thirty days of pregnancy.²² These unallowable coverage exclusions limit pregnant women's ability to travel outside of their service area by placing them at financial risk for the full cost of emergency maternity care, if needed. This restriction erodes the requirement that all plans must cover maternity care by creating unreasonable conditions whereby the issuer would not provide coverage.

Under the ACA, emergency services received outside of the service area or outside of the plan network must be covered for all enrollees, including pregnant women.²³ The coverage policies of these six issuers violate the emergency services protections of the ACA by

creating circumstances where they could deny coverage for emergency maternity services. If a pregnant woman goes into early labor, she would likely seek immediate medical attention. With 98 percent of births occurring in hospitals, a pregnant woman would likely go to a hospital emergency department if she experienced labor symptoms outside of her service area.²⁴

Under these restrictions on maternity coverage, a pregnant woman who seeks emergency maternity services outside of her service area could be denied coverage. Labor and delivery is the most expensive medical care most pregnant women are likely to receive. These unallowable provisions could leave women with the full financial responsibility for emergency maternity services, including labor and delivery.

PREVENTIVE SERVICES COVERAGE THAT FAILS TO COMPLY WITH THE ACA

FIFTY-SIX ISSUERS ACROSS 13 STATES OFFER COVERAGE OF PREVENTIVE SERVICES THAT DOES NOT COMPLY WITH THE ACA.

Violations of preventive services coverage requirements include:

- Imposing cost-sharing on women's preventive services
- Limiting frequency of well-woman visits and breastfeeding education
- Excluding required coverage for BRCA testing and breast pumps
- Failing to cover all birth control methods

Fifty-six issuers in 13 states offer preventive services coverage that does not comply with the ACA.

To encourage greater use of preventive services, address cost barriers to these services, and make sure all women have access to preventive health care, the ACA requires group and individual plans to cover certain preventive services with no cost-sharing requirements.²⁵ The law's emphasis on prevention and early detection represents a

huge step forward for women's health. Preventive care helps women live longer, healthier lives. Because women are more likely than men to avoid needed care because of cost, the availability of preventive services without cost-sharing is especially crucial.²⁶

These covered services are derived from four sets of expert recommendations: (1) services given an "A" or "B" recommendation by the U.S. Preventive Services Task Force (USPSTF); (2) all vaccinations recommended by the Center for Disease Control's Advisory Committee on Immunization Practices; (3) a set of evidence-based services for infants, children, and adolescents based on guidelines developed by the American Academy of Pediatrics and the Health Resources and Services Administration (HRSA); and (4) a set of additional evidence-based preventive services for women supported by HRSA.²⁷

The ACA directed HRSA to address women's preventive health by identifying additional screenings and services needed to fill gaps in preventive care. HRSA enlisted the Institute of Medicine (IOM) to conduct a review of effective preventive health measures for women. In response, the IOM convened a committee of experts—including specialists in disease prevention, women's health, and evidence-based care—to develop a set of recommendations. The IOM recommended eight preventive services targeted to women, and HRSA adopted the IOM's recommendations in full.

As a result, QHPs are required to cover eight preventive services for women: the full range of FDA-approved birth control methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity; well-woman visits; screening for gestational diabetes; breastfeeding support, supplies, and counseling; human papillomavirus testing; counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; and domestic violence screening and counseling.

Of the many USPSTF recommendations and HRSA-required services, this analysis targets a subset of services that are particularly important to women. These include: birth control, breastfeeding

ACA PROVISIONS ON PREVENTIVE SERVICES

The ACA requires coverage of certain preventive services, recommend by USPSTF and HRSA. This analysis reviewed coverage for: breastfeeding support and supplies, well-woman visits, genetic testing, and birth control.

Key regulations:

The preventive services are implemented through regulations at 45 CFR 147.130 and federal guidance from the U.S. Department of Labor, FAQs about Affordable Care Act Implementation (Part XII). Key points include:

- Issuers cannot impose cost-sharing on women's preventive health services.
- Issuers must permit women to use additional well-woman visits, without cost-sharing, to obtain all necessary preventive services, depending on a woman's health status, health needs, and other risk factors.
- Issuers must provide coverage of comprehensive lactation support and counseling and costs of renting or purchasing breastfeeding equipment, which extends for the duration of breastfeeding.

In addition, the Essential Health Benefits rules at 45 CFR 156.115 incorporate these requirements into EHB.

support and supplies, well-woman visits, and genetic testing. In addition, the Center examined all issuers' language on cost-sharing for preventive services.

Imposing Cost-Sharing on All Women's Preventive Services

THREE ISSUERS IN TWO STATES REQUIRE COST-SHARING FOR PREVENTIVE SERVICES IN VIOLATION OF THE ACA.

Violations of preventive services coverage requirements include:

- Imposing cost-sharing on all of women's preventive services
- Subjecting preventive services to the plan deductible in some cases

Three issuers in two states offer coverage of preventive services that does not comply with the ACA by imposing cost-sharing on preventive services. Not only is this an explicit violation of the ACA, it also could deter women from obtaining important benefits.

Two issuers in Nevada impose cost-sharing on *all* women's preventive services.²⁸ One issuer in Minnesota that offers a catastrophic plan impermissibly limits coverage of preventive services to the three primary care visits that catastrophic plans must cover before the deductible.²⁹ This policy does not comply with the ACA because preventive services covered under § 2713 of the Public Health Service Act do not count towards the three primary care visits that catastrophic plans must cover before the deductible.³⁰

Cost-sharing on preventive services could deter women from obtaining important benefits. Women would have to pay out-of-pocket for services their plan is required to cover—such as co-payments for preventive care visits or birth control prescriptions—or forgo services altogether. If her plan has a high deductible, a woman could be responsible for the full cost of her visit and medication, both of which should be provided without any cost-sharing.

WORKING TOWARDS BETTER COVERAGE COST-SHARING FOR PREVENTIVE SERVICES

In 2014, Anthem BlueCross and Anthem BlueCross Multi-State Plan in Nevada imposed cost-sharing for required preventive services by stating, “[w]omen’s Preventive Care services, as noted in the Health Resources and Services Administration guidelines, are covered but are subject to a cost share.” This was a clear violation of the ACA’s requirement to provide women’s preventive services at no cost-sharing.

The Center contacted state advocates and collaborated on a joint letter to the Nevada Insurance Commissioner. In February 2015, the Insurance Commissioner responded and indicated that the issuer corrected this violation, and it does not appear in the 2015 coverage documents.

Creating Unallowable Limits on Breastfeeding Support and Supplies

TWENTY ISSUERS IN SIX STATES IMPOSE IMPERMISSIBLE LIMITS ON COVERAGE OF BREASTFEEDING SUPPORT, SUPPLIES, AND COUNSELING.

Violations of breastfeeding coverage requirements include:

- Limiting coverage of breast pumps
- Limiting coverage of lactation counseling and education

Twenty issuers in six states offer coverage of breastfeeding support and supplies that does not comply with the ACA. Violations include limitations on breast pumps and lactation counseling.

Breastfeeding benefits the mother and the child, but too often there is a gap between women's intent to breastfeed their babies and the support they need to successfully breastfeed. Although a majority of women plan to breastfeed, a much lower proportion actually do when they are discharged from the hospital after delivery.³¹ After reviewing the clinical evidence, the Institute of Medicine recommended women receive comprehensive lactation support, counseling, and access to breastfeeding equipment. Based on this recommendation, the ACA requires coverage of breastfeeding support and supplies without co-payments, deductibles, or co-insurance for the duration of breastfeeding.

Limiting coverage of breast pumps

Coverage of breast pumps varies by issuer and state, with coverage limitations falling into distinct patterns that unallowably limit the scope of coverage. Three issuers in three states explicitly exclude breast pumps from coverage.³² Three issuers in two states only allow women to obtain a breast pump within 6 months of delivery.³³ Two issuers in one state limit rental of a breast pump to

12 months, while two issuers in two states indicate that the plan determines the duration of breast pump rentals.^{34,35} One issuer in Ohio limits coverage of a breast pump to one purchase every three years.³⁶ All of these examples conflict with federal guidance requiring issuers to cover breastfeeding equipment and support for the duration of breastfeeding.³⁷

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 chose to, without cost barriers.³⁸

Limiting coverage of lactation counseling and education

Coverage documents often say very little about lactation services. When it is mentioned, many issuers place significant limits on coverage that conflict with federal guidance. Nearly all issuers in Connecticut restrict access to lactation services to a narrow window, requiring women to get services within two months of delivery.³⁹ Three issuers in Connecticut go further by restricting coverage to a single lactation visit, also within two months of delivery.⁴⁰ Similarly, one issuer in Alabama limits breastfeeding education to two services per calendar year (for pregnant women) and three counseling sessions in conjunction with each birth.⁴¹ In addition, one issuer in Tennessee limits breastfeeding education to one visit per pregnancy.⁴²

All of these restrictions violate the ACA. Federal guidance clarifies that breastfeeding support and counseling extends for the duration of breastfeeding.⁴³ Furthermore, these restrictions could hamper women's ability to breastfeed successfully by significantly limiting access to lactation support.

Some women may need intensive lactation support to manage initial breastfeeding challenges such as insufficient milk supply or a newborn's difficulty latching. In other instances, women will need lactation support after breastfeeding has been established, but the woman needs treatment for medical issues associated with breastfeeding, such as thrush or mastitis, is returning to work, or experiences milk supply problems later in breastfeeding.

The IOM's breastfeeding recommendation encompasses the initiation and duration of breastfeeding. These coverage limits not only conflict with federal guidance but also undermine the intent of the IOM recommendation.⁴⁴

Limiting Well-Woman Visits

FIVE ISSUERS IN FOUR STATES DO NOT COVER WELL-WOMAN VISITS AS REQUIRED BY THE ACA.

Violations of well-woman coverage requirements include:

- Limiting women to a single visit per year
- Limiting the scope of services to gynecological exams

Five issuers in four states limit coverage of well-woman visits by having frequency or service limitations that do not comply with the ACA. Well-woman visits are a crucial entry point for women to access recommended preventive services. The IOM recommends coverage for well-woman visits to close a long-standing gap in coverage for women, remove the cost barriers women face when seeking preventive services, and address the fragmented nature of women's health care. These visits also create a unique opportunity for women to learn about their health risks, plan for preventive care, and receive education and counseling about maintaining or achieving healthy lifestyles throughout their lifespans.

WELL-WOMAN VISITS

Please visit www.nwlc.org/wellwoman for more information on well-woman care, particularly the education and counseling services that are a critical component of well-woman visits. These pages feature the Center's work in partnership with the Mary Horrigan Connors Center for Women's Health and Gender Biology at Brigham and Women's Hospital.

While the majority of coverage policies are silent on coverage of well-woman visits, some issuers limit well-woman visits in ways that conflict with federal guidance and the IOM recommendations. Three issuers in two states limit well-woman visits to a single visit per year.⁴⁵ One issuer in Alabama restricts coverage of a well-woman visit to two per calendar year.⁴⁶ One issuer in Rhode Island not only limits a well-woman visit to a single visit, but restricts the scope of that visit to a gynecological exam.⁴⁷

Federal guidance notes that women may need more than one well-woman visit per year to obtain the full complement of recommended preventive services.⁴⁸ The HRSA guidelines recommend *at least* one well-woman preventive care visit annually so that a woman may access the USPSTF and HRSA-recommended preventive services that are appropriate to her age, health status, disease risk factors, and other criteria.⁴⁹ A one-visit-per-year limit and restrictions on the scope of services violate the ACA. Well-woman visits are also intended to be comprehensive and are not limited to a gynecological exam. According to HRSA, these visits may encompass a wide range of women's health needs, including cardiovascular health, mental health, and substance use screenings.

Coverage policies that restrict well-woman care could limit women's access to covered preventive services. For example, some preventive services, such as mammograms or genetic counseling, may require women to visit a provider or facility other than their primary care practice. A limit on the number of well-woman visits a woman may receive in a calendar year could therefore result in women paying inappropriate cost-sharing when they receive these services. While the issuer would likely still cover the preventive service without cost-sharing, women may be asked to pay a copayment or coinsurance for the visit itself—and decades of research have demonstrated that cost-sharing can depress use of necessary care.⁵⁰ Similarly, policies that impermissibly restrict well-woman care to gynecological services could lead to women going without other screenings and services that are appropriate to their age and health histories.

LIMITING COVERAGE OF STI COUNSELING

One issuer in Alabama places both service limitations and age restrictions on coverage of important services for women. The issuer only provides coverage for three sexually transmitted infections (STI) counseling sessions “per lifetime.” This issuer also restricts the age limit for chlamydia screening to 15-24. USPSTF recommendations do not have this timeframe, rather they recommend screening for chlamydia in sexually active women age 24 years and younger, and in older women who are at increased risk for infection.

Further, the USPSTF makes recommendations about the effectiveness of specific clinical preventive services based on the benefits and risks associated with various screenings and tests. These recommendations sometimes include factors such as age, family history, and other risks for disease—however, all age and frequency-related recommendations are based on clinical evidence. All issuers must adhere to the USPSTF recommendations for age and frequency rather than creating any arbitrary limits.

The Center did not review all plans for violations related to STI screenings and counseling, but this issuer’s violations are included because of their specific nature.

Excluding or Limiting Coverage for Genetic Testing

SEVEN ISSUERS IN THREE STATES OFFER COVERAGE OF GENETIC TESTING THAT DOES NOT COMPLY WITH THE ACA.

Violations of genetic testing coverage requirements include:

- Excluding genetic testing
- Limiting coverage of genetic testing to overly-narrow circumstances

Seven issuers in three states offer coverage of genetic testing that does not comply with the ACA. Genetic testing gives women the chance to learn if their family history of breast or ovarian cancer is due to an inherited gene mutation. Women who have a BRCA1 or BRCA2 mutation have a greatly increased risk of breast cancer and ovarian cancer, and may require more intensive and frequent screening for these cancers. In some circumstances women with these mutations may choose surgery or chemoprevention to reduce their risk.

All issuers are required to cover genetic counseling and testing for BRCA1 and BRCA2 mutations for women at high-risk for family-related breast or ovarian cancer. However, these issuers’ plan documents prohibit coverage of these required services. For example, one issuer considers genetic testing only as part of a fertility evaluation.⁵¹ Four issuers indicate that genetic testing is not covered unless it is used to diagnose a condition, or determine a treatment plan for an already-diagnosed patient.⁵² Two issuers exclude all “genetic testing, counseling, or engineering” except for prenatal diagnosis of congenital conditions.⁵³

The USPSTF has made a B recommendation for genetic counseling and genetic testing for these mutations for women with a high risk for family-related breast and ovarian cancer, which means that issuers are required to provide this coverage and these exclusions violate the ACA. Women whose plans do not cover genetic counseling and testing for BRCA mutations and cannot afford to pay for these expensive services may not have the information they need to manage their cancer risk.

Coverage of Birth Control, Sterilization, and Related Education and Counseling

33 ISSUERS IN 13 STATES OFFER BIRTH CONTROL COVERAGE THAT DOES NOT COMPLY WITH THE ACA.

Violations of birth control coverage requirements include:

- Failure to cover all FDA-approved methods
- Cost-sharing on birth control
- Limits on services associated with birth control
- Age limits on birth control

Thirty-three issuers in 13 states offer birth control coverage that does not comply with the ACA.

The IOM recommended that birth control coverage be included as a preventive service in the ACA because the health benefits of birth control are well-documented.⁵⁴ Birth control is highly effective at reducing unintended pregnancy, which can have severe negative health consequences for both women and children. It also allows women to space their pregnancies, which improves the health of both women and their children. Birth control is such a core part of women's lives that 99 percent of sexually active women have used birth control at some point.⁵⁵

The ability of women to plan and space their pregnancies through access to birth control is linked to their greater educational and professional opportunities and increased lifetime earnings.⁵⁶ Access to reproductive health care can also benefit children later in life: a recent study shows that children whose mothers had access to birth control have higher family incomes and college completion rates.⁵⁷

Failing to cover all FDA-approved methods of birth control

Fifteen issuers in seven states fail to cover all FDA-approved methods of birth control. One issuer in South Dakota does not cover the contraceptive implantable

ACA PROVISIONS ON BIRTH CONTROL COVERAGE

The ACA requires qualified health plans to provide coverage without cost-sharing of all FDA-approved birth control methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.

Key parts of this requirement include:

- All FDA-approved birth control methods must be covered.
- FDA-approved over-the-counter contraceptive methods, when prescribed for women, must be covered.
- Birth control-related services, such as follow-up visits, management of side effects, counseling for continued adherence, and device removal must be covered.

Issuers may use “reasonable medical management techniques” to determine the “frequency, method, treatment, or setting” for birth control, such as imposing costs on a branded drug when a generic equivalent is covered. However, these techniques are not without limits:

- If a generic version is not available, issuers must cover the branded drug without cost-sharing.
- Every plan must have a waiver process that would let women access the birth control method she and her provider determine is medically appropriate for her.

rod.⁵⁸ An issuer in California fails to cover ella, a unique emergency contraceptive method, by defining “emergency contraceptive drugs” as those which have the same medication as “regular birth control drugs.”⁵⁹ An issuer in Wisconsin excludes coverage of contraceptive sponges.⁶⁰ In these instances, a woman may not be able to get coverage for the method of birth control that she and her medical provider have determined is appropriate for her, and is required by law. This could lead to women forgoing birth control altogether or using an inappropriate method, which could lead to less effective or less consistent use.

Eleven issuers in five states exclude over-the-counter (OTC) birth control methods.⁶¹ These OTC exclusions raise particular concerns about women's access to some forms of emergency contraception (EC) which are available over-the-counter. According to federal guidance, plans must cover FDA-approved over-the-counter birth control methods without cost-sharing when prescribed.⁶² Coverage of over-the-counter birth control methods is critical for women who rely on these methods to prevent pregnancy, and especially for access to EC so that a woman can prevent pregnancy if her primary birth control method fails or in cases of sexual assault.

Imposing cost-sharing on birth control

Seven issuers in three states require cost-sharing for birth control, some on all birth control methods while others impose cost-sharing on specific methods. A catastrophic plan in Maryland applies the deductible to "family planning services," including birth control.⁶³ Three issuers in Connecticut impose cost-sharing on sterilization services.⁶⁴ Two issuers in Ohio charge cost-sharing for IUDs and injectable contraceptives.⁶⁵ Another issuer in Ohio requires women to pay out-of-pocket for over-the-counter methods, but will reimburse women for those costs.⁶⁶

All of these examples impermissibly require women to pay cost-sharing—which could have a significant financial impact that deters women from obtaining required benefits. Of particular concern are the costs imposed on the most effective forms of birth control, such as IUDs, whose upfront costs without insurance coverage are nearly a month's salary for a woman working full-time at minimum wage.⁶⁷ Cost-sharing for IUDs has been shown to be a significant barrier—only 25 percent of women who request an IUD have one placed after learning the associated costs.⁶⁸ Issuers that impose cost-sharing on IUDs violate the ACA, create a financial obstacle to women accessing these more effective methods, and could prevent a woman from using the birth control that is most appropriate for her.

Limiting and imposing cost-sharing on services associated with birth control

Seven issuers in six states require cost-sharing for or place impermissible limits on services associated with

birth control. Two California issuers require cost-sharing for the physician office visits for injectable contraception and for diaphragm fitting procedures.⁶⁹ An issuer in Alabama limits coverage of sterilization confirmation tests to two tests per lifetime.⁷⁰ An issuer in South Dakota will only cover IUD placement and removal once every five years.⁷¹ The law does not allow these kinds of limitations.

Some plans require cost-sharing for, or impose impermissible limits on, birth control counseling. Multiple plans offered by one issuer in Colorado require cost-sharing, co-payments and/or deductibles, for birth control counseling.⁷² An issuer in Florida requires office visit charges for preventive medicine services including "contraception management, patient education, and counseling."⁷³ An Ohio issuer limits contraceptive counseling to two visits per year.⁷⁴ These unallowable costs and coverage limits could prevent a woman from receiving the counseling she needs to find the birth control method that is right for her. Counseling is also critical to helping women use their birth control method correctly, such as knowing how often to apply a patch, take a pill, or return to the office for an injection.

Requiring cost-sharing for brand-name birth control without generic equivalents

Eight issuers in five states cover generic oral birth control without cost-sharing, and impose cost-sharing on brand-name contraceptives.⁷⁵ An issuer in Ohio only covers generic injectable contraceptives, generic emergency contraceptives, and generic devices.⁷⁶ Any policy that limits coverage of birth control without cost-sharing only to generic forms is impermissible. Federal guidance specifies that issuers must cover brand name contraceptives without cost-sharing if a generic equivalent is not available.⁷⁷ In addition, where a generic equivalent is available, plans must have a waiver process for cases in which a provider has determined that the brand is the medically appropriate choice. Failure to cover brand-name birth control, when required, could leave women without access to the method of birth control best suited for them. Some women have adverse reactions to certain types of birth control and are unable to tolerate using that specific method. When this is the case for a generic and she is able to tolerate the brand-name version, she must have coverage of that version without cost-sharing.

Failing to cover sterilization for all women of reproductive capacity

Five issuers in three states impose impermissible limitations on sterilization. Specifically, an issuer in South Dakota excludes sterilization for “dependent children”—which includes adults up to the age of 26.⁷⁸ This provision would leave many adult women without coverage for this procedure, even though the ACA’s birth control benefit encompasses all women of reproductive capacity. In addition, two issuers exclude coverage of re-sterilization following a reversal of sterilization.⁷⁹ Another issuer limits coverage of sterilization to one procedure per lifetime.⁸⁰ If a prior sterilization procedure has been reversed, and a woman has reproductive capacity, the plan must cover a subsequent sterilization procedure under the ACA. Sterilization is the second-most used form of birth control, with 15.5 percent of all women relying on it.⁸¹ Plans cannot limit coverage of this birth control method.

Imposing age limits on birth control coverage

One issuer in one state denies coverage of birth control without cost-sharing based on a woman’s age, regardless of her reproductive capacity. An issuer in Colorado limits coverage to women under age 50.⁸² But, many women over the age of 50 continue to use birth control to prevent pregnancy.⁸³ Plans cannot arbitrarily limit coverage of birth control based on age because the ACA requires coverage for *all* women with reproductive capacity. If a woman’s health care provider determines she needs birth control, the plan must provide that coverage.

WORKING TOWARDS BETTER COVERAGE BIRTH CONTROL COVERAGE

After finding the violations in plans in Connecticut, the Center, along with Planned Parenthood of Southern New England, brought the problem to the attention of regulators in Connecticut. The state subsequently issued a clarifying bulletin about the birth control coverage requirements. Specifically, the bulletin directed issuers to ensure that sterilization and over-the-counter birth control is covered without any cost-sharing. The bulletin is an important step towards ensuring that issuers clearly understand the requirements of the law and are not inappropriately charging women cost-sharing.

ABORTION COVERAGE THAT FAILS TO COMPLY WITH THE ACA

ONE ISSUER IN ONE STATE IMPERMISSIBLY LIMITS COVERAGE OF ABORTION.

This issuer offers different abortion coverage to enrollees based on whether they receive financial help with their premiums.

One issuer in one state offers different abortion coverage to enrollees based on whether they receive financial help with their premiums, which is a violation of the ACA.

The ACA treats abortion differently from all other health care services, imposing limitations and rules that restrict women's access to insurance coverage of abortion.⁸⁴

Currently, 25 states have laws prohibiting QHPs from covering abortion in some or all instances.⁸⁵ Of the 15 states included in this report, six of them prohibit some or all coverage of abortion in QHPs: Alabama, Florida, Ohio, South Dakota, Tennessee, and Wisconsin. These bans take a critical benefit away from women, endangering women's health. Abortion coverage is permitted in the remaining nine states reviewed for this report. In those states, coverage of abortion varied across plans.

An issuer in Colorado offers different coverage to enrollees based on whether they receive financial help with their premiums. Specifically, it excludes coverage

ACA PROVISIONS ON ABORTION COVERAGE

The ACA treats abortion differently from other health care services.

- The ACA allows states to pass laws prohibiting abortion coverage in the Marketplaces.
- If a QHP covers abortion beyond certain limited circumstances, there are administrative requirements it must meet to ensure that federal financial assistance does not pay for those abortion services.

of abortion in any circumstance for individuals who receive help with their premiums, while offering other enrollees coverage for "non-elective procedures."⁸⁶ This differentiation is not allowed under the regulations implementing cost sharing reductions.⁸⁷ In addition, even within the severe limitations on abortion coverage in the ACA, QHPs are not authorized to treat enrollees receiving help with their premiums differently from those who are not in terms of abortion coverage within a plan. It is a violation of the ACA and would leave women receiving help with their premiums without the health care coverage that others in the plan receive. When it comes to a decision about whether or not to end a pregnancy, it's important that a woman has health coverage so that she can afford to make a real decision.

WORKING TOWARDS BETTER COVERAGE TREATING ENROLLEES DIFFERENTLY FOR ABORTION COVERAGE

In 2014, the Center worked with advocates at Colorado Consumer Health Initiative to contact New Health Ventures because it provided different coverage of abortion based on whether an enrollee received federal financial assistance, in violation of the ACA. The issuer corrected the problem in the 2015 plans.

ADDITIONAL ESSENTIAL HEALTH BENEFIT COVERAGE THAT FAILS TO COMPLY WITH THE ACA

SEVEN ISSUERS IN FOUR STATES IMPERMISSIBLY LIMIT ESSENTIAL HEALTH BENEFITS IN WAYS THAT RESTRICT WOMEN'S ACCESS TO CRITICAL SERVICES.

Violations of Essential Health Benefits coverage requirements include:

- Establishing limits more restrictive than state benchmark coverage
- Imposing waiting periods for certain services

Seven issuers in three states impermissibly limit coverage of Essential Health Benefits in ways that are particularly critical for women.

All qualified health plans are required to cover the ten categories of EHB: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The Essential Health Benefits are critically important to women. The EHB correct longstanding benefit gaps in the individual market and serve as the foundation of health coverage for QHPs sold in the Marketplaces. The EHB help ensure that women have the health coverage they need for a range of medical conditions, such as pregnancy, cancer, arthritis, and autoimmune conditions.

States can choose from a number of “typical employer plans” as the starting point for defining Essential Health Benefits. States identify one of these plans and then add additional coverage to ensure that it complies with federal regulation—creating an “EHB-benchmark plan” that serves as the basis for QHP coverage in that state.

ACA PROVISIONS ON ESSENTIAL HEALTH BENEFITS

According to § 1301 of the Affordable Care Act, all qualified health plans must offer Essential Health Benefits (EHB). Section 1302 of the ACA defines EHB to include ten categories of services, and stipulates that EHB must:

- Be equal in scope to a typical employer plan;
- Reflect an appropriate balance across categories of benefits;
- Not discriminate based on an individual's age, expected length of life, disability, degree of medical dependence, or quality of life;
- Take into account the health needs of diverse populations, including women, children, persons with disabilities, and other groups.

45 CFR 156 establishes standards for EHB. These regulations include:

- Requiring QHPs to provide coverage that is substantially equal to the state EHB benchmark, including limitations on this coverage;
- Allowing issuers to substitute benefits within an EHB category, if the substitution is actuarially equivalent, unless the state prohibits substitution;
- Requiring QHPs to cover the greater of one drug in every category or class of the US Pharmacopeia, or the number of drugs in each category and class covered by the benchmark plan; and
- Prohibiting issuers from using benefit designs that discriminate against individuals based on age, expected length of life, disability, degree of medical dependence, quality of life, or other health conditions.

Each issuer is required to use the EHB-benchmark plan to determine the scope of coverage they will offer on the Marketplaces. According to federal rules, issuers' covered benefits must be substantially equal to the state's benchmark plan. States may allow issuers to substitute benefits within the ten EHB categories, as long as the substitution is actuarially equivalent. Coverage of EHB cannot include discriminatory benefit designs and must be balanced across EHB categories.

Unallowable Restrictions on Essential Health Benefits

Improperly limiting drug coverage

Three issuers in two states exclude self-injectable medications from coverage.⁸⁸ As a result, women may not have coverage for medication necessary to treat conditions such as rheumatoid arthritis, lupus, or multiple sclerosis—conditions that predominantly affect women. This exclusion improperly limits prescription drug coverage. All QHPs must cover the greater of one drug per category or class or the number of drugs per category or class covered by the benchmark. Given the design of the states benchmarks' pharmaceutical benefit, plans cannot meet this requirement for all categories and classes if they do not cover any self-injectable medications.

Failing to cover devices

A Colorado issuer unallowably excludes coverage of “permanent or temporary implantation of artificial, non-human or mechanical organs and devices.”⁸⁹ This language would exclude breast implants used in breast reconstruction, which are regulated as devices by the Food and Drug Administration. This exclusion is not allowable. The law requires EHB to be equal to the scope of benefits offered by a typical employer plan – which are required to cover breast reconstruction following mastectomy.⁹⁰ Similarly, the Colorado benchmark specifically covers breast reconstruction.⁹¹ In addition, EHB regulations require plans to meet the health needs of women. Approximately two-thirds of breast reconstruction procedures use breast implants⁹²; a woman whose QHP does not cover breast implants may not be able to choose the reconstruction technique most appropriate to her

clinical circumstances and physique. An issuer who excludes breast implants from coverage therefore violates EHB.

Restricting coverage of maintenance therapies

Two issuers in Connecticut improperly exclude coverage for maintenance therapy.⁹³ Depending on the issuer's interpretation of the exclusion, the restriction could exclude a broad array of treatments and services that are covered by the EHB. Connecticut does not allow substitution of EHB benefits, which means that the plans must cover all services included in the EHB.⁹⁴ This restriction could exclude many treatments that should be covered under the EHB, such as hormonal therapy following initial breast cancer treatment, maintenance therapies for lupus, and maintenance therapies that prevent opportunistic infections in people with HIV.⁹⁵ Women who do not have coverage for maintenance therapies may be at risk for cancer recurrence, accelerated progression of auto-immune disease, or unnecessary complications for other conditions.

Excluding transplant coverage for new enrollees

In their 2014 plans, three issuers in two states exclude from coverage transplant services for new enrollees. Transplants are costly medical procedures but often provide life-saving results; limiting coverage of transplants in this way could be extremely dangerous for women's health. Two issuers in Washington State do not cover transplant services for individuals who had not been enrolled for the previous 90 days, thereby creating a three month waiting period for coverage.⁹⁶ A Colorado issuer goes further and restricts coverage to individuals enrolled for the previous year.⁹⁷

Guidance from the Department of Health and Human Services clearly states that such benefit-specific waiting periods are not allowed in Marketplace plans. The guidance noted concerns that such waiting periods “discourage enrollment of or discriminate against individuals with significant health needs or present or predicted disability.”⁹⁸ In addition to violating the EHB, these waiting periods—regardless of duration or limitations on the type of transplants that are excluded from coverage—also violate the ACA's ban on pre-existing conditions.⁹⁹

Waiting periods for transplant services not only violate the ACA but also have the effect of excluding coverage for timely, life-saving treatment. Women may not be able to pay the full cost of an organ transplant without insurance coverage. Women may have to choose less effective treatment options or forgo care and potentially suffer poorer health outcomes because of this violation.

WORKING TOWARDS BETTER COVERAGE COVERAGE OF TRANSPLANT SERVICES

The Washington State Office of the Insurance Commissioner began to look into transplant waiting periods after consumers contacted the office complaining about discriminatory waiting periods. While state regulators were reviewing these policies, HHS issued guidance clearly stating that waiting periods are not allowed on any EHB. Washington State regulators then ensured that all 2015 plans eliminated waiting periods for this critical service.

DISCRIMINATORY BENEFIT DESIGN THAT FAILS TO COMPLY WITH THE ACA

NINETY-SIX ISSUERS ACROSS 12 STATES OFFER COVERAGE THAT DOES NOT COMPLY WITH NON-DISCRIMINATION PROVISIONS OF THE ACA.

Some of these discriminatory provisions include:

- Denying or restricting maternity coverage
- Restricting coverage based on age
- Excluding coverage for chronic pain treatment
- Excluding coverage related to gender transition for transgender individuals

Ninety-six issuers across 12 states have explicitly discriminatory provisions in their plan documents.

Prior to the ACA, health insurance issuers engaged in a number of discriminatory and unfair practices. Women were routinely charged more than men for health insurance coverage, even coverage that excluded maternity care.¹⁰⁰ Health insurance issuers in the individual market denied coverage to anyone for almost any reason, and excluded coverage for pre-existing conditions.¹⁰¹ Not only did insurance plans exclude coverage of maternity care—a health care service only women need—but they routinely treated being a woman as a pre-existing condition, making it hard, and sometimes impossible, for women to find coverage that would meet their needs.¹⁰²

The ACA includes several provisions designed to correct this longstanding discrimination. QHPs must offer coverage to everyone, and cannot exclude those with pre-existing conditions.¹⁰³ Issuers are also prohibited from charging women more than men for insurance coverage.¹⁰⁴ Essential Health Benefits also cannot be denied to someone because of the individual's age, expected length of life, disability, degree of medical dependency, or quality of life.¹⁰⁵ This prohibition on discrimination in the EHB helps ensure that plans do not use plan design or other means to unlawfully deny or restrict coverage. The ACA also includes an anti-discrimination provision, § 1557, which contains

ACA PROVISIONS TO PREVENT DISCRIMINATION

The ACA prohibits discrimination in the Essential Health Benefits. Specifically:

- An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.
- A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

Section 1557 of the ACA prohibits discrimination in health care programs, including QHPs, on the basis of race, color, national origin, sex, sex stereotypes, gender identity, age, or disability.

broad prohibitions on discrimination in health care programs on the basis of race, color, national origin, sex, sex stereotypes, gender identity, age, or disability.¹⁰⁶ This is the first time that federal law has prohibited sex discrimination in health care.

Despite these prohibitions some issuers continue to offer plans with discriminatory benefit designs that restrict women's access to health care services or exclude services on a discriminatory basis.

Denying or restricting maternity care

As discussed previously in this report, two issuers in two states exclude dependent enrollees from maternity coverage and six issuers across three states exclude coverage of maternity care or services related to labor and delivery outside the service area.¹⁰⁷

It is well-established civil rights law that discrimination based on pregnancy and pregnancy-related conditions is per se sex discrimination.¹⁰⁸ Section 1557 follows this

precedent.¹⁰⁹ Thus, treating maternity coverage differently than other coverage is a violation of § 1557. This includes barring any beneficiary—including those who get their insurance through their parents or a spouse—from receiving maternity coverage. It also includes singling out maternity care as an excluded coverage outside of the plan service area.

Restricting coverage based on age

Nine issuers in two states exclude coverage based on age. As mentioned previously in this report, one issuer in Wisconsin impermissibly limits the services a pregnant woman can receive based on her age. The issuer limits coverage of prenatal vitamins and folic acid to women under age 42.¹¹⁰ Eight issuers in Connecticut impermissibly restrict coverage for infertility services based on age.¹¹¹ Connecticut includes infertility services in its EHB benchmark plan but also limits this coverage to individuals under age 40. Thus QHPs in the state must include this coverage and eight issuers in Connecticut also include the age limit in their benefit design. The age limit in the Connecticut benchmark is an arbitrary limit that denies women over the age of 40 a health service based solely on their age. Because the average age of menopause is 51, many women over 40 still have reproductive capacity and a medical need for prenatal care and infertility services.¹¹² Thus, the Connecticut benchmark itself, the QHPs offered in Connecticut with the age limit, and the Wisconsin QHP with the age limit violate the ACA.¹¹³

Excluding coverage of chronic pain treatment

Two issuers in Colorado exclude “[s]ervices or supplies for the treatment of intractable pain and/or chronic pain” and “[t]reatment at pain clinics and chronic pain centers.”¹¹⁴ Women report more frequent pain, more severe pain and pain of a longer duration than men.¹¹⁵ Women are at least four times more likely than men to be diagnosed with four conditions associated with chronic pain: chronic fatigue syndrome, fibromyalgia, interstitial cystitis, and temporomandibular (TMJ) disorders.¹¹⁶ About 6.3 million women are affected by endometriosis in the US and about 6 million women are affected by vulvodynia in the US, two chronic pain conditions impacting only women.¹¹⁷

Chronic pain conditions, such as arthritis or rheumatism, and back or spine problems are the two leading causes

of disability. Untreated pain has a detrimental effect on quality of life.¹¹⁸ Plans providing EHB cannot have benefit designs that discriminate based on disability or quality of life. HHS has interpreted this provision to mean that benefit designs that discourage enrollment by individuals based on a health condition are discriminatory benefit designs.¹¹⁹ In addition, QHPs are prohibited by § 1557 of the ACA from discriminating against individuals with disabilities. The chronic pain exclusion discourages individuals that have chronic pain conditions from enrolling in plans with these issuers because the services to treat their pain are specifically excluded. These plans therefore discriminate against individuals with disabilities and reduced quality of life due to conditions with chronic pain in violation of the ACA.

Excluding care for transgender people

Ninety-two issuers in 12 states explicitly exclude care related to gender transition for transgender individuals. In some states, such as Ohio, the EHB benchmark excludes transition-related care. In some instances issuers broadly exclude all transition-related services, such as those services related to “sex transformation; gender dysphoric disorder; gender reassignment” or “treatment leading to or in connection with transsexualism.”¹²⁰ Other issuers

specifically exclude transition-related surgery, sometimes referred to as “transgender surgery” or “transsexual surgery,” or exclude hormone therapy for transgender individuals.¹²¹ In addition, some issuers specifically exclude transition-related services within the mental health benefit.¹²²

These exclusions discriminate on the basis of sex, gender identity, and health condition in violation of EHB and § 1557 of the ACA. The exclusions apply only to transgender individuals. The majority of transition-related services fall within the EHB categories of ambulatory care, mental health services, prescription drugs, and laboratory services, and most if not all interventions excluded from coverage for transgender individuals are routinely covered for non-transgender people to treat other medical conditions.¹²³ For example, patients with hypogonadism and other endocrine disorders as well as menopausal symptoms may use hormone therapy. Likewise, psychotherapy is a medically necessary treatment for a wide variety of conditions. In addition, these exclusions discourage transgender individuals from enrolling in these plans. Excluding transgender services from coverage violates the ACA by denying access to coverage based on sex, gender identity, and health condition.

WORKING TOWARDS BETTER COVERAGE EXCLUDING CARE FOR TRANSGENDER PEOPLE

In 2014, all issuers in Washington and Connecticut excluded transition-related care. Because of the work of state and national advocates, state regulators in Washington and Connecticut issued guidance ending discrimination based on gender identity in health insurance. The Washington State Insurance Commissioner issued a letter to health insurance carriers that cites § 1557 of the ACA, as well as the state’s Law Against Discrimination, and clarifies that “broad exclusions of coverage on the basis of gender identity” and “denial of a medically necessary service on the basis of gender identity” are prohibited. The Connecticut Insurance Department issued guidance based on state nondiscrimination law.

Thanks to this guidance, no issuers in Washington or Connecticut explicitly exclude transition-related care in their 2015 plans.

The Colorado Division of Insurance issued similar guidance and most issuers removed explicit transition-related care exclusions; however two issuers continued to have discriminatory exclusions in 2015.

Recommendations

THE ACA CORRECTS LONGSTANDING PROBLEMS WITH THE INDIVIDUAL HEALTH INSURANCE MARKET and makes significant improvements in coverage for the services women need to get and stay healthy. Federal and state officials, insurance issuers, consumer advocates, and women themselves must continue to push forward with these changes to fully realize the ACA's promise for women's health. All of these stakeholders have important roles to play to ensure that health plans in Marketplaces comply with the law and meet women's needs. The following recommendations will foster better plan compliance with the law's requirements, greater availability of plan information, more aggressive oversight, and better redress for consumers—with the end result of improving Marketplace coverage for women.

Issuers:

- Issuers **must know the law** and make sure the plans they offer **comply with the law**.
- Issuers must **correct identified problems** for the millions of women who hold QHP coverage today, and for those who will enroll in the future.
- Issuers must have **clear coverage policies** that reflect the scope of coverage within their plans and make these documents broadly available. Regulators who review and certify plans, and women who choose plans and use health services, need to know which services plans cover or do not cover.

State and federal regulators:

- State and federal regulators need to provide **stronger oversight** to ensure plans comply 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. States regulators must be diligent in their review of plan documents and determined in their efforts to bring

plans into compliance with the law during the certification process. They must be similarly diligent about correcting violations as they arise throughout the plan year. As the managers of federally-facilitated Marketplaces, and as the first-line regulator for the states that rely on federal review for plan certification, federal regulators must be equally diligent and determined. They cannot presume that state oversight alone is sufficient to ensure plan compliance with the law, and they must assume an active role as the Marketplace manager.

- State or federal regulators (as applicable) should **open all proposed plans for public comment**. This would give advocates and consumers a chance to review plans, and provide comments to regulators, on any violations present prior to plan certification.
- Regulators in every state should ensure that **coverage documents are publicly available, beginning with open enrollment**. Greater availability of plan documents would ensure that women have the opportunity to know the details of the plans they are purchasing. Information is a key feature of a well-functioning Marketplace—it allows women to choose the plans that are best for them and their families, and it increases competition among issuers to offer plans that meet women's needs. In addition, women's health advocates will be able to review and monitor plans for compliance after certification.
- 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 insurance reforms and what qualified health plans must cover. Women need this information to be informed consumers, to advocate for the coverage they need, and to hold plans accountable when they violate the law.

- Federal regulators should **collect data on plan violations** to inform further rulemaking or guidance to issuers and state regulators on ACA requirements. This data would reveal trends in issuer policies and problems with particular issuers that arise in multiple states.
- 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.

Consumers and Consumer Advocates:

- Women and their advocates should **educate themselves about their coverage rights** and **contact state and federal regulators** when issuers violate these rights. This contact can include appealing an adverse coverage decision, or alerting state and federal regulators when health plan documents do not appear to comply with the law.

In several states where the Center identified violations in 2014 plans, the Center worked with local advocates to approach state regulators or plans directly to improve compliance with the ACA.

Thanks to the work of the Center and state advocates, women can now count on better benefits in a range of Marketplace plans. These successes include:

- ✓ Removing exclusions of certain contraceptive methods;
- ✓ Ensuring full coverage of breast pumps by an issuer that previously excluded them from coverage;
- ✓ Removing limits on prenatal services from a policy that limited women to a single ultrasound;
- ✓ Removing a provision that excluded care for dependents from maternity coverage;
- ✓ Eliminating cost-sharing for women's preventive services in a plan that inappropriately charged women for preventive services; and
- ✓ Correcting coverage that limited abortions to enrollees not receiving financial help with their premiums.

Conclusion

THIS REVIEW OF PLAN DOCUMENTS IN 15 STATES FINDS THAT A MAJORITY OF THESE PLANS VIOLATE ACA REQUIREMENTS RELATED TO WOMEN'S HEALTH COVERAGE. These violations may relate to which services, drugs, or devices QHPs cover, whether—and how much—women will pay out-of-pocket for care that should be fully covered by their QHP, which women have coverage for critical health care services, and other limitations on the care women need. The extent of ACA violations in these 15 states suggests that women covered by other issuers, and in other states, may hold coverage that is also impermissibly limited.

Without question, insurance issuers are responsible for the plan documents they submit to regulators as they seek certification for plans they will offer in the Marketplaces. Issuers need to do better. At the same time, state and federal regulators must also do better by ensuring that QHPs offered in the Marketplaces meet the standards of the ACA and its implementing regulations and guidance.

The Center's experience working with issuers, state advocates, and state officials demonstrates that these violations can be identified and corrected. But without greater availability of plan information to inform this type of advocacy, and more systemic efforts to enforce the law, women's health coverage will remain at the mercy of insurance issuers whose previous practices drove the need for insurance reforms in the first place.

APPENDIX A: NUMBER OF ISSUERS WITH VIOLATIONS OF THE ACA IN EACH STATE

Number of Issuers with Violations of the ACA in Each State: 2014 and 2015							
State	Maternity	Breastfeeding Support and Supplies	Birth Control	Other Preventive Services	Abortion	Essential Health Benefits	Discrimination
Alabama 2015	1	1	1	1			
California 2014			1	1			
California 2015			1	1			
Colorado 2014	3	3		2	1	1	10
Colorado 2015	1	1	2	2		1	2
Connecticut 2014		2	2			1	3
Connecticut 2015		5	1			2	5
Florida 2015			1				4
Maine 2014			2	2			3
Maryland 2014			1				6
Minnesota 2014		1	2	1			
Nevada 2014	1		3	2			5
Nevada 2015	1		2				6
Ohio 2014	2	2	7				12
Ohio 2015		3	4				13
Rhode Island 2014			1	1			2
South Dakota 2014	1		1				1
Tennessee 2014	1	2		1			4
Washington 2014						2	9
Washington 2015							
Wisconsin 2014	3		2	1			12

APPENDIX B: LIST OF ISSUERS BY STATE AND YEAR

APPENDIX B		
Alabama		
Issuer	2014	2015
BlueCross BlueShield of AL	Plans were unavailable	Reviewed
Humana, Inc.	Plans were unavailable	Plans were unavailable
United HealthCare	Plans were unavailable	Plans were unavailable
California		
Issuer	2014	2015
BlueCross BlueShield	Plans were not offered or were unavailable	Plans were unavailable
Blue of California	Reviewed	Plans were unavailable
Chinese Community Health Plan	Reviewed	Reviewed
Contra Costa Health Plan	Reviewed	No longer offered
HealthNet	Reviewed	Plans were unavailable
Kaiser Permanente	Reviewed	Plans were unavailable
LA Care	Reviewed	Reviewed
Molina Healthcare	Reviewed	Plans were unavailable
Sharp	Plans were not offered or were unavailable	Plans were unavailable
Valley Health Plan	Reviewed	Reviewed
Western Health Advantage	Plans were not offered or unavailable	Plans were unavailable
Colorado		
Issuer	2014	2015
All Savers (UnitedHealthcare)	Reviewed	Plans were unavailable
Anthem BlueCross BlueShield	Reviewed	Reviewed
Anthem BlueCross BlueShield Multi-State Plan	Reviewed	Plan was available but not reviewed
CIGNA	Reviewed	Reviewed
Colorado Choice Health plans	Reviewed	Reviewed
Colorado Health OP	Reviewed	Reviewed
ELEVATE/Denver Health	Reviewed	Reviewed
Humana	Reviewed	Reviewed
Kaiser Permanente	Reviewed	Reviewed
New Health Ventures	Reviewed	Reviewed
Rocky Mountain Health Plans	Reviewed	Reviewed
Connecticut		
Issuer	2014	2015
Anthem BlueCross and BlueShield of CT	Reviewed	Reviewed
Anthem BlueCross and BlueShield Multi-State Plans	Plans were not offered or were unavailable	Reviewed

ConnectiCare	Reviewed	Reviewed
United Healthcare	Plans were not offered or were unavailable	Reviewed
Healthy CT	Reviewed	Reviewed
Healthy CT Multi-State Plans	Plans were not offered or were unavailable	Reviewed

Florida

Issuer	2014	2015
Assurant	Plans were not offered or were unavailable	Reviewed
Humana	Plans were not offered or were unavailable	Reviewed
Molina	Plans were not offered or were unavailable	Reviewed
Preferred Medical Plan	Plans were not offered or were unavailable	Reviewed

Maine

Issuer	2014	2015
Anthem BlueCross BlueShield	Reviewed	Plans were available but not reviewed
Anthem BlueCross BlueShield Multi-State Plan	Reviewed	Plan was no longer offered
Harvard Pilgrim	Plans were not offered or were unavailable	Plans were available but not reviewed
Maine Community Health Options CO-OP	Reviewed	Plans were available but not reviewed

Maryland

Issuer	2014	2015
All Savers (UnitedHealthcare)	Reviewed	Plans were unavailable
CareFirst Blue Choice	Reviewed	Plans were unavailable
CareFirst of Maryland	Reviewed	Plans were unavailable
CareFirst of Maryland Multi-State Plan	Reviewed	Plans were unavailable
CIGNA	Plans were not offered or were unavailable	Plans were unavailable
Evergreen Health CO-OP	Reviewed	Plans were unavailable
Group Hospitalization & Medical Services, Inc.	Reviewed	No longer offered
Kaiser Permanente	Reviewed	Plans were unavailable

Minnesota

Issuer	2015	2015
BlueCross BlueShield of MN	Reviewed	Plans were unavailable
HealthPartners	Reviewed	Plans were unavailable
Medica	Reviewed	Plans were unavailable
PreferredOne	Reviewed	No longer offered
UCare of MN	Reviewed	Plans were unavailable

Nevada		
Issuer	2014	2015
Anthem BlueCross Blue Shield	Reviewed	Reviewed
Anthem BlueCross Blue Shield Multi-State Plan	Reviewed	Reviewed
Nevada Health CO-OP	Reviewed	Reviewed
Prominence HealthFirst	Plans were not offered or were unavailable	Reviewed
Saint Mary's Health First	Reviewed	No longer offered
Time Insurance Company	Plans were not offered or were unavailable	Reviewed
Health Plan of NV	Reviewed	Reviewed

Ohio		
Issuer	2014	2015
Aetna	Plans were not offered or were unavailable	Reviewed
Anthem BlueCross Blue Shield	Reviewed	Reviewed
AultCare	Reviewed	Reviewed
Buckeye Community Health	Reviewed	Plans were unavailable
CareSource	Reviewed	Reviewed
Coordinated Health Mutual	Plans were not offered or were unavailable	Reviewed
Coventry Health America One	Reviewed	No longer offered
HealthSpan	Reviewed	Reviewed
Humana	Reviewed	Plans were unavailable
Kaiser Permanente	Reviewed	No longer offered
Medical Health Insuring	Reviewed	Reviewed
Molina	Reviewed	Reviewed
Paramount	Reviewed	Reviewed
Premier Health Plan	Plan was not offered or was unavailable	Reviewed
Summa	Reviewed	Reviewed
Time Insurance Company	Plan was not offered or was unavailable	Reviewed
UnitedHealthcare of Ohio	Plan was not offered or was unavailable	Reviewed

Rhode Island		
Issuer	2014	2015
BlueCross BlueShield of RI	Reviewed	Plans were available but not reviewed
Neighborhood Health Plan	Reviewed	Plans were available but not reviewed
United HealthCare	Plans were unavailable or not offered	Plans were unavailable

South Dakota		
Issuer	2014	2015
Avera Health Plans	Plans were unavailable or not offered	Plans were unavailable
DAKOTACARE/South Dakota State Medical Holding Company, Inc.	Plans were unavailable or not offered	Plans were unavailable
Sanford Health Plan	Reviewed	Plans were unavailable

Tennessee		
Issuer	2014	2015
Assurant	Plans were unavailable or not offered	Plans were unavailable
BlueCross Blue Shield of TN	Reviewed	Plans were unavailable
CIGNA	Reviewed	Plans were unavailable
Community Health Alliance	Reviewed	No longer offered
Humana	Reviewed	Plans were unavailable
Washington		
Issuer	2014	2015
BridgeSpan Health Company	Reviewed	Reviewed
Community Health Plan	Reviewed	Reviewed
Coordinated Care	Reviewed	Reviewed
Kaiser Permanente	Reviewed	No longer offered
LifeWise Health Plan	Reviewed	Reviewed
Moda Health Plan	Plans were not offered or were unavailable	Reviewed
Molina Healthcare	Reviewed	Reviewed
Premera Blue Cross	Reviewed	Plans were unavailable
Premera Blue Cross Multi-State Plan	Reviewed	Plans were unavailable
Wisconsin		
Issuer	2014	2015
Anthem BlueCross BlueShield	Reviewed	Plans were unavailable
Anthem BlueCross Blue Shield Multi-State Plan	Reviewed	Plans were unavailable
Arise Health Plan	Reviewed	Plans were unavailable
Common Ground CO-OP	Reviewed	Plans were unavailable
Dean Health Plan	Reviewed	Plans were unavailable
Gunderson Health Plan	Reviewed	Plans were unavailable
Health Tradition Health plan	Reviewed	Plans were unavailable
Medica Health Plans	Reviewed	Plans were unavailable
Molina Healthcare	Reviewed	Plans were unavailable
Physicians Plus	Reviewed	Plans were unavailable
Prevea 360 Health plan	Reviewed	No longer offered
Security Health Plan	Reviewed	Plans were unavailable
Unity Health Insurance	Plans were not offered or were unavailable	Plans were unavailable
United Healthcare	Plans were not offered or were unavailable	Plans were unavailable
Group Health Cooperative -SCW	Plans were not offered or were unavailable	Plans were unavailable
Ambetter from MHS Health WI	Plans were not offered or were unavailable	Plans were unavailable
MercyCare Health Plans	Plans were not offered or were unavailable	Plans were unavailable

Endnotes

- 1 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), (codified as amended in scattered sections of 26 U.S.C. & 42 U.S.C. (2013)).
- 2 Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, *Health Insurance Marketplaces 2015 Enrollment Report*, (March 2015) available at http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf
- 3 We counted issuers by state so the same insurance company could be counted multiple times if they offer plans in multiple states. We also counted the Multi-State Plans (MSPs) as a separate issuer even if the insurance company offered both MSPs and non-MSPs in the same state since the coverage policies could differ.
- 4 Garrett, D, National Women's Law Center, *Turning to Fairness* (2012) available at <http://www.nwlc.org/resource/report-turning-fairness-insurance-discrimination-against-women-today-and-affordable-care-ac>.
- 5 Garrett, *Turning to Fairness*.
- 6 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation ASPE Issue Brief: *Essential Health Benefits: Individual Market Coverage* (2011) available at <http://aspe.hhs.gov/health/reports/2011/individual-market/ib.shtml>.
- 7 Salganicoff, A., Ranji, U., Beamesderfer, A., Kurani, N., Kaiser Family Foundation, *Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey* (2014) available at <http://kaiserfamily-foundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf>
- 8 Garrett, *Turning to Fairness*.
- 9 Health Resources and Services Administration, U.S. Department of Health and Human Services, *Prenatal Services* (2014) available at <http://mchb.hrsa.gov/programs/womeninfants/prenatal.html>; Health Resources and Services Administration, U.S. Department of Health and Human Services, *Barriers to Prenatal Care, Child Health USA* (2013) available at <http://mchb.hrsa.gov/chusa13/health-services-utilization/p/barriers-to-prenatal-care.html>.
- 10 MacDorman MF, Mathews TJ, Mohangoo AD, Zeitlin J, "International comparisons of infant mortality and related factors: United States and Europe, 2010," in *National Vital Statistics Reports*; vol 63 no 5. Hyattsville, MD: National Center for Health Statistics, (2014) available at http://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_05.pdf.
- 11 MacDorman, "International comparisons of infant mortality and related factors: United States and Europe, 2010."
- 12 Community Health Alliance, offered in Tennessee (2014). This report did not review plans in Tennessee in 2015.
- 13 Buckeye Community Health, offered in Ohio (2014). This issuer corrected this violation. However this report did not review Buckeye Community Health (Ohio) in 2015.
- 14 45 CFR § 156.115(a)(2). Regulations state that the only exception to this rule is coverage of pediatric care, which adult enrollees can be excluded from receiving.
- 15 New Health Ventures, offered in Colorado (2014), the issuer removed this limit for 2015 plans; Sanford Health Plan, offered in South Dakota (2014). This report did not review plans in South Dakota in 2015.
- 16 BlueCross BlueShield of Alabama, offered in Alabama (2015).
- 17 Anthem BlueCross BlueShield and Anthem BlueCross BlueShield, Multi-State Plan, offered in Colorado (2014); Anthem BlueCross BlueShield, offered in Colorado (2015). This report did not review Anthem BlueCross BlueShield Multi-State Plan, offered in Colorado in 2015.
- 18 Physicians Plus, offered in Wisconsin (2014). This report did not review plans in Wisconsin in 2015.
- 19 45 CFR § 156.115(a)(1).
- 20 Centers for Medicare and Medicaid Services, *Colorado EHB Benchmark Plan* available at <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/colorado-ehb-benchmark-plan.pdf>; Centers for Medicare and Medicaid Services, *South Dakota EHB Benchmark Plan* available at <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/south-dakota-ehb-benchmark-plan.pdf>; Center for Medicare and Medicaid Services, *Alabama EHB Benchmark Plan* available at <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/alabama-ehb-benchmark-plan.pdf>; Centers for Medicare and Medicaid Services, *Wisconsin EHB Benchmark Plan* available from <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/wisconsin-ehb-benchmark-plan.pdf>.
- 21 For example, the Association of American Family Physicians recommends discussing family history during prenatal care to determine the need for genetic counseling. The American College of Obstetricians and Gynecologists includes preconception care as critical to optimizing women's health before planning and conceiving a pregnancy. See Kirkam, et al. "Evidence-Based Prenatal Care: Part I. General Prenatal Care and Counseling Issues," in *Am Fam Physician*. (2005) Apr 1;71(7):1307-1316 available at <http://www.aafp.org/afp/2005/0401/p1307.html> and ACOG Committee Opinion, "The Importance of Preconception Care in the Continuum of Women's Health Care " (2005) available at <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/The-Importance-of-Preconception-Care-in-the-Continuum-of-Womens-Health-Care>.

- 22 Saint Mary's Health First, offered in Nevada (2014 & 2015, the plan changed its name to Prominence Health Plan in 2015); Dean Health Plan, Physicians Plus, and Prevea 360 Health Plan, offered in Wisconsin (2014); CareSource, offered in Ohio (2014). The plan no longer included this violation.
- 23 Regulations define an emergency medical condition as a medical condition that a "prudent layperson" could reasonably expect to place the patient's health in serious jeopardy if they went without medical care. In the case of pregnant women, the criterion of serious jeopardy also applies to the health of the unborn child (45 CFR § 147.138 (b)(4)(i) (2010)). Plans must therefore cover unexpected labor, delivery, and urgent pregnancy-related complications as an emergency outside of the service area.
- 24 Centers for Disease Control and Prevention, *Trends in Out-of-Hospital Births in the United States, 1990–2012* (2014) available at <http://www.cdc.gov/nchs/data/databriefs/db144.htm>.
- 25 The ACA defines "cost-sharing" to include "deductibles, coinsurance, copayments, or similar charges."
- 26 Salganicoff, *Women and Health Care in the Early Years of the Affordable Care Act*.
- 27 45 CFR § 147.130
- 28 Anthem and Anthem Multi-State Plan, offered in Nevada (2014). The issuer corrected this violation and it does not appear in Anthem and Anthem Multi-State Plans offered in Nevada in 2015.
- 29 Preferred One Catastrophic Plan, offered in Minnesota (2014). This was not reviewed in 2015.
- 30 45 CFR § 156.155
- 31 Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps* (2011) Washington, DC: National Academies Press.
- 32 New Health Ventures, offered in Colorado (2014); Humana, offered in Ohio (2014); Humana offered in Colorado (2014); and Humana, offered in Tennessee (2014). New Health Ventures (CO) and Humana (CO) did not have this exclusion in 2015. Humana (OH) was not available for review in 2015. This report did not review QHPs in Tennessee in 2015.
- 33 Kaiser Permanente, offered in Colorado in (2014 & 2015); BlueCross Blue Shield of MN, offered in Minnesota (2014). The report did not review BlueCross Blue Shield of MN in 2015.
- 34 Kaiser Permanente, offered in Ohio (2014); Healthspan, offered in Ohio (2015).
- 35 UnitedHealthcare, offered in Connecticut (2015); UnitedHealthcare, offered in Ohio (2015).
- 36 Aetna, offered in Ohio (2015).
- 37 U.S. Department of Health and Human Services, *Affordable Care Act Implementation FAQs - Set 12* available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html
- 38 Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps*.
- 39 Anthem BlueCross BlueShield of Connecticut, offered in Connecticut (2014 and 2015); Anthem BlueCross BlueShield Multi-State Plan, offered in Connecticut (2015); Healthy CT, offered in Connecticut (2014 & 2015); Healthy CT Multi-State Plan, offered in Connecticut (2015).
- 40 Anthem BlueCross BlueShield of Connecticut offered in Connecticut (2014 and 2015); and Anthem BlueCross BlueShield Multi-State Plan, offered in Connecticut (2015).
- 41 BlueCross Blue Shield of Alabama, offered in Alabama (2015).
- 42 BlueCross BlueShield of Tennessee, offered in Tennessee (2014). The report did not review plans in Tennessee in 2015.
- 43 U.S. Department of Health and Human Services, *Affordable Care Act Implementation FAQs - Set 12*
- 44 Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps*.
- 45 Valley Health Plan, offered in California in (2014 & 2015). Health Tradition Health Plan, offered in Wisconsin (2014). This report did not review plans in Wisconsin in 2015.
- 46 BlueCross BlueShield of Alabama, offered in Alabama (2015) ("rider" on preventive services).
- 47 BlueCross BlueShield of Rhode Island, offered in Rhode Island (2014). This report did not review plans in Rhode Island in 2015.
- 48 U.S. Department of Health and Human Services, *Affordable Care Act Implementation FAQs - Set 12*. Specifically: "[i]f the clinician determines that a patient requires additional well-woman visits for this purpose, then the additional visits must be provided in accordance with the requirements of the interim final regulations (that is, without cost-sharing and subject to reasonable medical management)."
- 49 U.S. Department of Health and Human Services, Health Resources and Services Administration, *Women's Preventive Services Guidelines* available at <http://www.hrsa.gov/womensguidelines/>
- 50 Kathryn Swartz, "Cost Sharing: Effects on Spending and Outcomes," *The Synthesis Project: New Insights from Research Results*, The Robert Wood Johnson Foundation (December 2010), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1.
- 51 Humana Insurance, offered in Tennessee (2014). This report did not review Tennessee plans for 2015.
- 52 Rocky Mountain Health Maintenance Organization, offered in Colorado (2014); Anthem BlueCross BlueShield and Anthem

- BlueCross BlueShield Multi-State Plan, offered in Maine in (2014); Cigna, offered in Colorado (2015). Rocky Mountain HMO did not include this language in 2015; this report did not review Anthem BlueCross Blue Shield and Anthem BlueCross BlueShield Multi-State Plan offered in Maine for 2015.
- 53 Colorado Choice Health Plans, offered in Colorado in (2014 & 2015).
- 54 Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps*.
- 55 Kimberly Daniels et al., Contraceptive Methods Women Have Ever Used: United States, 1982–2010, *National Health Statistics Reports* No. 62, 4 (Feb. 14, 2013) available at <http://www.cdc.gov/nchs/data/nhsr/nhsr062.pdf>.
- 56 Jennifer J. Frost and Laura Duberstein Lindberg, Reasons for Using Contraception: Perspectives of US Women Seeking Care at Specialized Family Planning Clinics, 87 *Contraception* 465, 467 (2013) (“Economic analyses have found clear associations between the availability and diffusion of oral contraceptives[,] particularly among young women, and increases in U.S. women’s education, labor force participation, and average earnings, coupled with a narrowing in the wage gap between women and men.”); Adam Sonfield et al., Guttmacher Institute, “The Social and Economic Benefits Of Women’s Ability To Determine Whether And When To Have Children,” (2013) available at <http://www.guttmacher.org/pubs/social-economic-benefits.pdf> (providing an extensive review of studies that document how controlling family timing and size contribute to educational and economic advancements).
- 57 Martha J. Bailey, “Fifty Years of Family Planning: New Evidence on the Long-Run Effects of Increasing Access to Contraception,” *National Bureau of Economic Research* (October 2013), available at <http://www.nber.org/papers/w19493.pdf>.
- 58 Sanford Health Plan, offered in South Dakota (2014). This report did not review plans in South Dakota in 2015.
- 59 LA Care, offered in California (2014 & 2015).
- 60 Physicians Plus, offered in Wisconsin (2014). This report did not review Wisconsin plans for 2015.
- 61 Anthem BlueCross BlueShield and Anthem BlueCross BlueShield Multi-State Plan, offered in Maine (2014); Preferred One offered in Minnesota (2014); CareSource, CoventryHealthAmerica, Healthspan (the language in Healthspan in 2015 differs from 2014 and is not conclusive on whether all OTC birth control methods are covered without cost-sharing), and Molina (this language did not appear in Molina in 2015) all offered in Ohio (2014), and Anthem BlueCross BlueShield, offered in Ohio (2014 & 2015); BlueCross BlueShield of Rhode Island (2014); Arise Health Plan, offered in Wisconsin (2014). This report did not review plans in Maine, Minnesota, Rhode Island, and Wisconsin in 2015.
- 62 The Departments have made clear that the HRSA Guidelines include birth control that is generally available over-the-counter if the birth control is both FDA-approved and prescribed by the woman’s health care provider. See U.S. Department of Health and Human Services, *Affordable Care Act Implementation FAQs - Set 12*.
- 63 Kaiser Permanente, offered in Maryland (2014) (in the catastrophic plan, a woman must meet her deductible when getting her birth control covered); the issuer corrected this violation.
- 64 HealthyCT, offered in Connecticut (2014) (cost-sharing applied to sterilization services provided by a doctor, this exact language did not appear in HealthyCT in 2015); ConnectiCare, offered in Connecticut (2014 & 2015).
- 65 Kaiser Permanente, offered in Ohio (2014) and Healthspan, offered in Ohio (2015). The cost of the IUD is determined to be the lesser of the monthly co-payment multiplied by the number of months the IUD is effective according to the manufacturer or \$200. The cost to the enrollee of injectable contraceptives is the monthly co-payment multiplied by the number of months the injection is effective according to the manufacturer but cannot exceed the cost of the contraceptive itself.
- 66 Aetna, offered in Ohio (2015).
- 67 Brief of the Guttmacher Institute and Professor Sara Rosenbaum as Amici Curiae Supporting the Government at 16, *Burwell v. Hobby Lobby Stores, Inc.*, 134 S.Ct. 2751 (2014) (Nos. 13-354 & 13-356)
- 68 Aileen M. Garipey et al., “The Impact of Out-of-Pocket Expense on IUD Utilization Among Women with Private Insurance,” 84 *Contraception* (2011).
- 69 LA Care, offered in California (2014 & 2015).
- 70 BlueCross BlueShield, offered in Alabama (2015).
- 71 Sanford Health Plan, offered in South Dakota (2014). Not reviewed for 2015.
- 72 Kaiser Permanente offered in Colorado (2015).
- 73 Assurant, offered in Florida (2015).
- 74 Aetna, offered in Ohio (2015).
- 75 Saint Mary’s Health First, offered in Nevada (2014) and Prominence HealthFirst, offered in Nevada (2015); Summa, offered in Ohio in (2014 & 2015); Sanford Health Plan, offered in South Dakota (2014); Arise Health Plan, offered in Wisconsin (2014); BlueCross BlueShield of Alabama (2015). This report did not review plans in South Dakota and Wisconsin in 2015.
- 76 Aetna, offered in Ohio (2015).
- 77 Federal guidance states, “a generic version is not available, or would not be medically appropriate for the patient as a prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient), then a plan or issuer must provide coverage for the brand name drug.” See U.S. Department of Health and Human Services, *Affordable Care Act Implementation FAQs - Set 12*.

- 78 Sanford Health Plan, offered in South Dakota (2014). Not reviewed for 2015.
- 79 Nevada Health Co-op (2014) and Health Plan of Nevada (2014 and 2015), offered in Nevada (2014). This language was not included in the 2015 plan documents for Nevada Co-op.
- 80 BlueCross BlueShield, offered in Alabama (2015).
- 81 Centers for Disease Control and Prevention, National Center for Health Statistics, "Current Contraceptive Status Among Women Aged 15-44: United States, 2011-2013," *NCHS Data Brief No. 173* (Dec. 2014) available at <http://www.cdc.gov/nchs/data/databriefs/db173.htm>.
- 82 Colorado HealthOP, offered in Colorado (2015). The plan documents are unclear whether this limitation applies to all contraceptives, or only over-the-counter methods.
- 83 The average age of menopause, when a woman is no longer able to become pregnant, is 51. U.S. Department of Health & Human Services, National Institute of Health, "Menopause: Time for a Change" (Jan. 2008), available at <http://www.nia.nih.gov/health/publication/menopause-time-change/introduction-menopause>.
- 84 42 U.S.C. § 18023(a)(1).
- 85 National Women's Law Center, *State Bans on Insurance Coverage of Abortion Endanger Women's Health and Take Health Benefits Away from Women* (2015) available at <http://www.nwlc.org/resource/state-bans-insurance-coverage-abortion-endanger-women%E2%80%99s-health-and-take-health-benefits-awa>.
- 86 New Health Ventures, offered in Colorado (2014). This language was not included in the 2015 documents.
- 87 45 CFR § 156.410.
- 88 United HealthCare offered in Connecticut (2015); Colorado Choice offered in Colorado (2014 & 2015).
- 89 Colorado Choice, offered in Colorado (2014). This language was not included in the 2015 documents.
- 90 42 U.S.C. § 18022(b)(2)(A); 29 U.S. Code § 1185b.
- 91 Centers for Medicare and Medicaid Services, *Colorado EHB Benchmark Plan*.
- 92 Tang, S. and G. Gui, *InTech Implant and Implant Assisted Breast Reconstructions, Breast Reconstruction - Current Techniques*, M. Salgarello (Ed.) (2012) available at <http://cdn.intechopen.com/pdfs-wm/27942.pdf>
- 93 Anthem offered in Connecticut (2014 & 2015).
- 94 Giovannelli, J., K. Lucia, and S. Corlette. The Commonwealth Fund, *Implementing the Affordable Care Act: Revisiting the ACA's Essential Health Benefits Requirements* (2014) available at http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/oct/1783_giovannelli_implementing_aca_essential_hlt_benefits_rb.pdf. Additional issuers exclude coverage for maintenance therapy in states that allows substitution. It is unclear from the plan documents whether these issuers substituted other benefits for the maintenance therapy or whether the exclusions are a violation of EHB.
- 95 National Comprehensive Cancer Network, *NCCN Guidelines for Patients: Stage III Breast Cancer* (2014), available at: http://www.nccn.org/patients/guidelines/stage_iii_breast/index.html#54; U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, National Guideline Clearinghouse, *American College of Rheumatology Guidelines for Screening, Treatment, and Management of Lupus Nephritis* (2012) available at <http://www.guideline.gov/content.aspx?id=36900&search=%22maintenance+therapy%22>; U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, National Guideline Clearinghouse, *Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents. Recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America* (2013) available at <http://www.guideline.gov/content.aspx?id=45359&search=%22maintenance+therapy%22>.
- 96 Community Health Plan of Washington and Coordinated Care, offered in Washington (2014.) There were no waiting periods for transplants in these plans in 2015 following regulatory action by the Office of the Insurance Commissioner, Washington State Office of the Insurance Commissioner. Washington Administrative Code 284-43-878 available at <http://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/2014-03/documents/2014-03103P.pdf>.
- 97 Colorado Choice Health Plans, offered in Colorado (2014). This language was not included in the 2015 documents.
- 98 Centers for Medicare and Medicaid Services. (2014). *Frequently Asked Questions on Health Insurance Market Reforms and Marketplace Standards* available at <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Final-Master-FAQs-5-16-14.pdf>. More specifically, federal guidance clarifies that benefit-specific waiting periods are not allowed on any EHB by a plan that is required to provide the EHB.
- 99 The term "preexisting condition exclusion" is defined by federal regulations implementing § 2704 of the Public Health Services Act by reference to the definition used for the Health Insurance Portability and Accountability Act (HIPAA) definition at 45 CFR § 144.103, referring to the examples under the HIPAA regulations at 45 CFR § 144.111(a)(1)(ii). Example 5 in the regulations conclude that a 12 month waiting period for pregnancy benefits "is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage." Waiting periods for transplant services are similarly a subterfuge for a preexisting condition exclusion since individuals with a preexisting condition underlying the need for transplant services would be denied coverage for those services during the waiting period.
- 100 Garrett, *Turning to Fairness*.

- 101 Kaiser Family Foundation, *Health Insurance Market Reforms: Pre-Existing Condition Exclusions* (2012) available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8356.pdf>.
- 102 Codispoti, L., B. Courtout and J. Swedish, National Women's Law Center, *Nowhere To Turn* (2008) available at <http://www.nwlc.org/sites/default/files/pdfs/NWLCReport-NowhereToTurn-81309w.pdf>;
Grady, D. , *Overhaul Will Lower the Costs of Being a Woman*, New York Times (March 29, 2010) available at <http://www.nytimes.com/2010/03/30/health/30women.html>.
- 103 42 U.S. Code § 300gg-1.
- 104 42 U.S. Code § 300gg.
- 105 42 U.S. Code § 18022(b)(4)(B).
- 106 42 U.S.C. § 18116.
- 107 Community Health Alliance, offered in Tennessee (2014); Buckeye Community Health, offered in Ohio (2014); Saint Mary's Health First, offered in Nevada (2014 & 2015, the plan changed its name to Prominence Health Plan in 2015); Dean Health Plan, Physicians Plus, and Prevea 360 Health Plan, offered in Wisconsin (2014); CareSource, offered in Ohio (2014), in 2015, the plan no longer included this violation.
- 108 It is well established under civil rights laws such as Title IX and Title VII that a health insurance plan that provides comprehensive coverage to its beneficiaries but fails to provide comprehensive coverage for women— including full coverage for gynecological and maternity care—is discriminating on the basis of sex. See, e.g., 34 CFR §§ 106.39, 106.40 (2012) (stating that Title IX requires comprehensive gynecological care when a recipient provides full coverage for health services and that a recipient must treat pregnancy in the same manner it treats other conditions); 29 CFR pt. 1604 app. (stating that Title VII, amended by the Pregnancy Discrimination Act, requires that any employer-provided health insurance must cover expenses for pregnancy related conditions on the same basis as expenses for other medical conditions); *Newport News Shipbuilding & Dry Dock v. EEOC*, 462 U.S. 669 (1983) (holding that Pregnancy Discrimination Act, which amended Title VII, required employer health plan to cover pregnancy-related conditions for employees' spousal dependents on the same basis as other conditions covered for dependent spouses).
- 109 Section 1557 states, "an individual shall not, on the ground prohibited under . . . title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.," 42 U.S.C. § 18116 (2012). Under Title IX and other civil rights laws, sex discrimination includes, but is not limited to, discrimination based on pregnancy, pregnancy-related conditions, marital or familial status, gender identity, and sex-stereotyping. See Letter from Leon Rodriguez, Dir. of Office for Civil Rights, Department of Health & Human Services to Maya Rupert, Federal Policy Director for the National Center for Lesbian Rights (Jul. 12, 2012) (OCR Transaction No. 12-000800) See also, 34 C.F.R. §§ 106.39, 106.40 (2012) (stating that Title IX requires comprehensive gynecological care when a recipient provides full coverage for health services and that a recipient must treat pregnancy in the same manner it treats other conditions).
- 110 Physicians Plus, offered in Wisconsin (2014). This report did not review plans in Wisconsin in 2015.
- 111 Anthem BlueCross BlueShield, offered in Connecticut (2014 & 2015); Anthem BlueCross BlueShield Multi-State Plan, offered in Connecticut (2015); Connecticare, offered in Connecticut (2014 & 2015); Healthy Connecticut, offered in Connecticut (2014 & 2015); United Healthcare, offered in Connecticut (2015); Physicians Plus, offered in Wisconsin (2014). This report did not review plans in Wisconsin in 2015.
- 112 U.S. Department of Health & Human Services, National Institute of Health, "Menopause: Time for a Change" (Jan. 2008), available at <http://www.nia.nih.gov/health/publication/menopause-time-change/introduction-menopause>.
- 113 42 U.S. Code § 18022 and 45 CFR 156.125.
- 114 Colorado Choice Health Plans, offered in Colorado (2014 & 2015).
- 115 Campaign to End Chronic Pain in Women, *Chronic Pain in Women: Neglect, Dismissal and Discrimination* (2010) available at <http://www.endwomenspain.org/Page/14/13>.
- 116 Campaign to End Chronic Pain in Women, *Chronic Pain in Women: Neglect, Dismissal and Discrimination* (2010) available at <http://www.endwomenspain.org/Page/14/13>.
- 117 Institute of Medicine, Committee on Advancing Pain Research, Care, and Education, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* (2011) available at <https://www.iom.edu/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research.aspx>.
- 118 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, (2009) *Prevalence and Most Common Causes of Disability Among Adults - 2005* available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5816a2.htm>; Katz, N. (2002) The Impact of Pain Management on Quality of Life, *Journal of Pain Symptom Management*; 24(1 Suppl):S38-47 available at <http://www.jpmsjournal.com/article/S0885-3924%2802%2900411-6/pdf>.
- 119 Preamble to 45 CFR Parts 144, 147, 153, et al. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule Page 10822.
- 120 All Savers Insurance Company, offered in Maryland (2014); CareFirst of Maryland, Inc. (2014); CareFirst Blue Choice, offered in Maryland (2014); Evergreen Health Cooperative, Inc., offered in Maryland (2014); Group Hospitalization & Medical Services, Inc., offered in Maryland (2014); Kaiser Permanente, offered in Maryland (2014); Assurant, offered in Florida (2015); Humana,

offered in Florida (2015); Time Insurance Company; offered in Nevada & Ohio (2015). Please refer to the appendices to track changes in discriminatory benefit design and transition-related services in 2014 and 2015, among states reviewed in this report.

- 121 All Savers Insurance Company, offered in Colorado (2014); CIGNA, offered in Colorado (2014 & 2015); Colorado Choice Health Plans (2014 & 2015); Elevate by Denver Health Medical Plans, offered in Colorado (2014); Anthem BlueCross BlueShield HMO Colorado (2014); Anthem BlueCross BlueShield HMO Multi-State Plan offered in Colorado (2014); Humana, offered in Colorado (2014); Kaiser Permanente, offered in Colorado (2014); New Health Ventures, Inc., offered in Colorado (2014); Rocky Mountain Health Plans, offered in Colorado (2014); Anthem BlueCross BlueShield, offered in Connecticut (2014); ConnectiCare Benefits, Inc., offered in Connecticut (2014); Healthy CT, offered in Connecticut (2014); Anthem BlueCross BlueShield, offered in Maine (2014); Anthem BlueCross BlueShield Multi-State Plan, Offered in Maine (2014); Maine Community Health Options (2014); Anthem BlueCross BlueShield Multi-State Plan, offered in Nevada (2014 & 2015); Anthem BlueCross Blue Shield, offered in Nevada (2014 & 2015); Saint Mary's Health First, offered in Nevada (2014& 2015) (the plan changed its name to Prominence HealthFirst in 2015); Humana, offered in Ohio (2014); Kaiser Permanente, offered in Ohio (2014); Ault Insurance Company, offered in Ohio (2014 & 2015); Buckeye Community Health Plan, offered in Ohio (2014); CareSource, offered in Ohio (2014 & 2015); Anthem BlueCross BlueShield, offered in Ohio (2014 & 2015); Coventry Health, offered in Ohio (2014); HealthSpan, Inc., offered in Ohio (2014 & 2015); Medical Health Insuring Corporation, offered in Ohio (2014 & 2015); Molina Healthcare, offered in Ohio (2014 & 2015); Paramount Insurance Company, offered in Ohio (2014 & 2015); Summa Insurance Company, offered in Ohio (2014 & 2015); BlueCross Blue Shield of Rhode Island (2014); Neighborhood Health Plan of Rhode Island (2014); Sanford Health Plan, offered in South Dakota (2014); BlueCross Blue Shield of Tennessee, offered in Tennessee (2014); CIGNA, offered in Tennessee (2014); Community Health Alliance, offered in Tennessee (2014); Humana, offered in Tennessee (2014); BridgeSpan Health Company, offered in Washington (2014); Community Health Plan of Washington (2014); Coordinated Care Cooperation, offered in Washington (2014); Kaiser Permanente, offered in Washington (2014); Lifewise Health Plan of Washington (2014); Molina Healthcare of Washington (2014); Premera Blue Cross, offered in Washington (2014); Premera Blue Cross Multi-State Plan, offered in Washington (2014); Anthem BlueCross BlueShield Multi-State plan, offered in Wisconsin (2014); Anthem BlueCross BlueShield, offered in Wisconsin (2014); Arise Health Plan, offered in Wisconsin (2014); Common Ground Healthcare Cooperative, offered in Wisconsin (2014); Dean Health Plan, Inc., offered in Wisconsin (2014); Gundersen Health Plan, Inc., offered in Wisconsin (2014); Health Tradition, offered in Wisconsin (2014); Medica Health Plans, offered in Wisconsin (2014); Molina Healthcare of Wisconsin (2014); Physicians Plus, offered in Wisconsin (2014); Prevea360 Health Plan, offered in Wisconsin (2014); Security Health Plan of Wisconsin, Inc.(2014); Molina, offered in Florida (2015); Preferred Medical Plan, offered in Florida (2015); Aetna, offered in Ohio (2015); Premier Health Plan, Inc., offered in Ohio (2015); UnitedHealthcare of Ohio (2015); Coordinated Health Mutual, offered in Ohio (2015). Please refer to the appendices to track changes in discriminatory benefit design and transition-related services in 2014 and 2015, among states reviewed in this report.
- 122 Nevada Health CO-OP (2014 & 2015); United Plan of Nevada (2014 & 2015); Community Health Plan of Washington (2014). Please refer to the appendices to track changes in discriminatory benefit design and transition-related services in 2014 and 2015, among states reviewed in this report.
- 123 California Code of Regulations (CCR) tit. 10 § 2561.2(a)(4)(A) (listing hormone therapy, hysterectomy, mastectomy, and vocal training as illustrative examples of treatments commonly covered for other conditions which may not be excluded for gender dysphoria); Oregon Insurance Bulletin 2012-1, Application of Senate Bill 2 (2007 Legislative Session) to Gender Identity Issues in the Transaction & Regulation of Insurance in Oregon 3 (2012), available at <http://www.oregon.gov/DCBS/insurance/legal/bulletins/Documents/bulletin2012-01.pdf>



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