
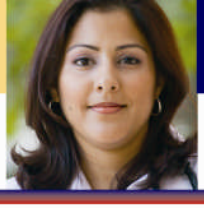

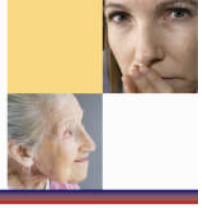

What Women Need To Know about Health Reform: Making Health Care More Affordable

June 2010

The comprehensive health care reform that President Obama signed into law includes many provisions that make health care more affordable and protect families from financial risk. This aspect of reform is particularly important for women. Because they are poorer (on average)[1] and use more care,[2] women spend a greater share of their income on their health needs. They struggle disproportionately with medical bills or debt, and are more likely than men to forgo necessary health care because of cost.[3] Being female also increases the likelihood of declaring medical bankruptcy.[4] The new health reform law addresses the "affordability gap" that women currently face and makes it easier for women to get the care they need, when they need it.

Health Reform Protects Women from Financial Risk and Medical Bankruptcy

- Health plans are prohibited from imposing lifetime limits, meaning they can no longer limit the amount of money they will pay for benefits over an individual's lifetime.[5] This protection takes effect for all health plans (including existing plans) starting in September 2010*, and is especially beneficial for women with high health care expenses, such as those with disabilities, chronic conditions, and serious illnesses.
- Similarly, health plans are prohibited from limiting the amount of money they will pay for benefits during one year.[5] Annual limits are "restricted" (as defined by the Secretary of Health and Human Services) starting in September 2010*, and are completely prohibited by 2014.* The provision applies to all new plans and existing group plans.
- The annual deductibles (i.e. set dollar amounts that an individual must pay before insurance coverage begins) for new health plans sold to small groups—defined as up to 100 employees—are limited to a maximum of $2,000 for single coverage and $4,000 for family coverage, starting in 2014. Currently, deductibles for small group health plans are higher, on average, than deductibles for larger groups.[6]
- All new health plans are required to include limits on annual out-of-pocket spending (e.g. spending towards deductibles and other forms of enrollee "cost-sharing") on covered health services. The cost-sharing limits are based on IRS guidelines for high-deductible health plans. Projected limits for 2014, when this provision takes effect, are a maximum of $6,200 for an individual health plan and $12,300 family plan.[7]

Health Reform Expands Access to Affordable Health Insurance Plans

- Up to 4.5 million women will be newly eligible for coverage through Medicaid, the joint federal-state health insurance program for low-income people that provides a comprehensive set of health benefits with few, if any, cost-sharing requirements.[8] By 2014 (at the latest), states must extend Medicaid eligibility to those up to 133% of the federal poverty level (FPL), or roughly $29,000 a year for a family of four.

* Protections are in effect for health plan years beginning *on or after* this date, e.g. if your insurance plan is renewed on January 1, 2011, the new provisions take effect at that time. Some health plans have announced that they will voluntarily implement certain provisions earlier than required.

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- Currently, even women living in extreme poverty are unlikely to qualify for Medicaid unless they are also pregnant, parenting, or disabled. By establishing a uniform eligibility income level, health reform extends coverage to millions of low-income uninsured women who were previously ineligible.

- Approximately 11 million low- and middle-income women will receive subsidies to help purchase health coverage through the new Health Insurance Exchanges, the easy-to-use "insurance shopping centers" where women can compare and choose the high-quality health plan that best fits their needs.[9]
  - Starting in 2014, the subsidies will be available to women living in families with incomes up to 400% of the FPL (roughly $88,000 a year for a family of four), provided that they are not eligible for other acceptable coverage (e.g. Medicare, Medicaid/CHIP).
  - The subsidies are based on a sliding scale and limit the amount that an individual/family pays for health premiums. For instance, a woman with an income at 150% of the FPL ($16,245) will pay no more than $650 per year towards her health premium. A family of four with an income at 300% of the FPL ($66,150) will pay no more than $6,284 per year towards their health premium.[10]
  - The subsidies will be provided as tax credits that are both *refundable* (available even to very low-income women with limited or no tax liability) and *advanceable* (or made available at the beginning of a year for use whenever health insurance premiums are due).

- Low- and middle-income women who are eligible for premium subsidies will also be eligible for subsidies to help reduce any cost-sharing (e.g. deductibles and copayments) required by their Exchange-based health plan. Women living in families with incomes up to 400% of the FPL will have a reduced limit on out-of-pocket spending, and those with incomes up to 250% of the FPL may also qualify for further reductions in cost-sharing.[11]

- Though women who are eligible for an employer-sponsored insurance (ESI) are generally ineligible for health insurance subsidies, women who are eligible for ESI that is deemed "unaffordable" can turn down the offer and receive health insurance subsidies to buy coverage through the Exchange instead. To qualify, a woman's share of the ESI premium must exceed 9.5% of household income, or the ESI plan must have a significantly lower value than the plans available through the Exchange.

Health Reform Makes Health Care Services More Affordable

- Beginning in September 2010, all new health plans are required to cover key preventive health services for women, with no cost-sharing. To ensure that copayments and deductibles are no longer a barrier to preventive care, the law requires plans to cover and eliminate cost-sharing for all preventive services and screenings recommended by the US Preventive Services Task Force (USPSTF). Insurers are also required to cover—with no cost-sharing—key preventive health services for women in particular, to be defined by a designated federal agency.

- Health reform also authorizes $11 billion over 5 years for Community Health Centers (CHCs) to expand their operational capacity and enhance medical, oral, and behavioral health services. CHCs are a vital part of the health safety-net and provide affordable health care to low-income and uninsured clients on sliding fee scale. Given that a segment of the uninsured population will remain without coverage even after health reform is fully implemented, this provision is essential to ensuring that all women have

access to affordable health care.

For more information on women and the health reform law, visit the National Women's Law Center website: www.nwlc.org/reformmatters

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[1] National Women's Law Center, *Falling Short in Every State: The Wage Gap and Harsh Economic Realities for Women Persist* (2009), http://www.nwlc.org/fairpay/statefacts.html.
[2] Elizabeth Patchias and Judy Waxman, National Women's Law Center, *Women and Health Coverage: The Affordability Gap* (2007), http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf.
[3] Sheila D. Rustgi, Michelle M. Doty, and Sara R. Collins, The Commonwealth Fund, *Women at Risk: Why Many Women are Forgoing Needed Health Care* (2009), http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/May/Women-at-Risk.aspx.
[4] A medical bankruptcy is a bankruptcy that has a medical cause. See: David Himmelstein, et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine* (pub. online June 5, 2009), http://www.amjmed.com/article/S0002-9343(09)00404-5/abstract.
[5] This prohibition applies to covered benefits that are deemed "essential health benefits" by the Secretary of Health and Human Services. Health benefits which are not "essential health benefits" may be subject to lifetime limits if otherwise permitted by federal and state law.
[6] Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2009 Annual Survey* (2010), http://ehbs.kff.org/?page=abstract&id=2.
[7] Projections are from the U.S. Congress Joint Committee on Taxation, as cited in the Tri-Committee House Staff comparison chart of the House and Senate bills (January 2010), available at: http://www.speaker.gov/pdf/HScomparison.pdf
[8] National Women's Law Center calculations based on health insurance data for women ages 18-64 from the Current Population Survey's 2008 Annual Social and Economic Supplement, using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html
[9] *Ibid.* Includes an estimated 8.1 million uninsured women and 2.9 million women who currently purchase coverage from the individual health insurance market.
[10] Premium credits will not be available until 2014, but the examples provided in this fact sheet are based on current (2010) federal poverty levels, to provide an illustration of what women and their families would pay under their current income levels.
[11] If necessary, cost-sharing may be further reduced to ensure that a low-income person's health plan has a certain "actuarial value". Actuarial value is the percent of covered medical expenditures that a plan is likely to pay, if a "standard" population is enrolled in the plan. Cost-sharing will be further reduced so that plans for people with incomes up to 150% of the FPL must have an actuarial value of 94%; for incomes up to 200% of the FPL the actuarial value must be 87%; and for incomes up to 250% of the FPL the actuarial value must be 73%.