
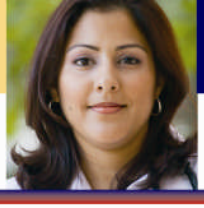

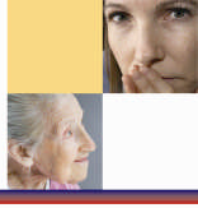

# What Women Need to Know about Health Reform: Coverage for the Health Care Services You Need

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Today, too many women struggle to find insurance coverage for the benefits they need. Women use more health care than men on average, in part due to their reproductive health care needs. They are also more likely to suffer from a chronic condition requiring ongoing care, such as asthma or arthritis.[1] Because many health plans do not cover a comprehensive set of health benefits, even women with insurance are too often forced to choose between paying out-of-pocket for necessary services—or delaying or skipping that care altogether.

The health reform law recently signed by President Obama includes many provisions of particular importance to women. Specifically, health reform will help women access many of the health services they need by establishing a list of "essential health benefits"—categories of health care services—which new individual and small group health plans will have to cover, such as preventive care, maternity, and mental health. However, the new health reform law treats abortion differently from all other services and places unnecessary requirements relating to abortion coverage on individuals and health care plans.

## Health Reform Requires Coverage for Many Important Health Services for Women

- Health reform establishes a package of "essential health benefits"—categories of basic health care services—which all new health insurance plans sold to individuals and small businesses will be required to cover (beginning in 2014).
- Many of the required categories of health care services—such as maternity care, prescription drugs, and mental health services—are particularly important for women, who represent two-thirds of all users of mental health services[2] and spend more than men on prescription drugs.[3] The maternity coverage requirement is especially critical, as it is currently very difficult—and sometimes impossible—for women to find coverage that includes maternity care when they buy coverage on their own.[4]
- While the law outlines the broad categories of services that insurers must cover, it will be up to the Secretary of Health and Human Services to flesh out the details. To ensure that the set of required health care services is comparable to the coverage available in a "typical" employer-sponsored health plan, the law tasks the Secretary of Labor with conducting a survey of the benefits currently covered under employer-sponsored plans.

## Health Reform Requires Coverage for Key Preventive Services for Women—with No Cost-Sharing

- Beginning in September 2010, all new health plans must cover and eliminate cost-sharing (e.g., co-payments and deductibles) for preventive services and screenings recommended by the US Preventive Services Task Force. This ensures that cost is no longer a barrier to preventive care.
- Insurers will also be required to cover—with no cost-sharing—key preventive health services for women, to be defined by a designated federal agency.
- Eliminating cost-sharing for preventive services will greatly benefit women, who use more preventive care than men[5] but are also more likely than men to forgo preventive care,

such as a cancer screening or dental exam, due to cost.[6] Studies have shown that even moderate co-pays for preventive services such as mammograms or pap smears deter patients from receiving the service.[7]

## Health Reform Treats Abortion Differently from All Other Services and Places Unnecessary Requirements on Individuals and Health Care Plans

- Health reform treats abortion care—a key component of reproductive health care for women—differently than all other health care services. Abortion is prohibited from being a required benefit for plans in the new Health Insurance Exchanges (easy-to-use "insurance shopping centers" that will begin operating in 2014) and health care plans will determine whether or not to cover abortion. Health care plans cannot use federal funds for abortion services beyond those permitted under the Hyde Amendment (in cases of life endangerment, rape, and incest) and plans that include coverage for such services will be required to follow certain requirements to segregate private funds.
- Individuals enrolled in a health care plan offered through an Exchange that includes coverage of abortion will be required to make two separate payments for their health insurance – one for abortion coverage and another for the remainder of the premium.
- There must be at least one multistate plan (i.e. a plan sold in more than one state) offered through each Exchange that does not cover abortion services beyond those permitted under the Hyde Amendment.
- Women's health advocates are working to mitigate any potential problems stemming from these requirements and encourage plans to continue to cover this basic women's health service.

## Health Reform Improves Supports for Long Term Care Recipients and Caregivers

- Health reform creates a new national, voluntary insurance program (known as the Community Living Assistance Services and Supports, or CLASS) to provide long-term care and supports, such as home modifications, respite care, personal assistance services, home care aides, and nursing support (beginning as early as 2011).
- This will create new options for those older women who enroll, who are more likely than men to need assistance with daily activities. Indeed, among people age 75 or older, women are 60% percent more likely than men to need help with at least one daily activity, such as eating or dressing.[8]
- Importantly, CLASS benefits can be used to compensate a family caregiver—a big help for women, who are more likely than men to be an unpaid family caregiver.[9]
- Health reform also encourages states to improve and expand access to long-term services and supports under their Medicaid programs, and offers states new flexibility to provide these services in the setting of an enrollee's choice (including at home or in a community-based facility).

## Health Reform Also Expands Federal "Mental Health Parity" Requirements

- A federal law passed in 2008 requires that mental health and substance abuse services be treated equally to physical health benefits—i.e. not subject to increased financial requirements or treatment limitations—in large group health plans (50 employees or more) that already provide some level of mental health coverage.

- Health reform applies those protections to all individual health plans (including existing plans) beginning in 2014.[10] In addition, all health plans sold to individual and groups through the new Exchanges must meet requirements for mental health parity.
- Improving mental health coverage is critical for women, 16 million of whom—14% of women ages 18 and over—used prescription medication in 2006 for treatment of an emotional or mental condition. An estimated 10 million adults in the U.S. needed but did not receive mental health care in 2006, and more than half of women with an unmet mental health need cited cost or lack of insurance coverage as the reason they didn't receive these necessary services.[11]

**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] Salganicoff et al., The Kaiser Family Foundation, *Women and Health Care: A National Profile* (KFF, Menlo Park, CA: July 2005); U.S. Census Bureau, Statistical Abstract of the United States: 2009, "Table 159 – Ambulatory Care Visits to Physicians' Offices and Hospital Outpatient and Emergency Departments: 2006."
[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Women's Health USA 2008,* "Mental Health Care Utilization" (2008), http://mchb.hrsa.gov/whusa08/hsu/pages/309mhcu.html.
[3] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Women's Health USA 2008* "Health Care Expenditures" (Rockville, Maryland: U.S. Department of Health and Human Services, 2008).
[4] Brigette Courtot and Julia Kaye, National Women's Law Center, *Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition* (Oct. 2009), http://www.nwlc.org/pdf/stillnowheretoturn.pdf.
[5] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, "Utilization of Ambulatory Medical Care by Women: United States, 1997-98," *Vital and Health Statistics*, Series 13, Number 149 (Hyattsville, Maryland: U.S. Department of Health and Human Services, July 2001); Asch et al., Who is At Greatest Risk for Receiving Poor-Quality Health Care?, *The New England Journal of Medicine 354*, no.11 (March 16, 2006) 1147-56.
[6] 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.
[7] Solanki G and Schauffler HH, *Cost-sharing and the utilization of clinical preventive services,* Am J Prev Med 17, no.2 (Aug 1999) 127-133; Trivedi et al., *Effect of Cost Sharing on Screening Mammography in Medicare Health Plans,* New England Journal of Medicine 358, no.4, 375-383 (January 2008).
[8] AARP Public Policy Institute analysis of data from the 2005 National Health Interview Survey. Ari Houser, AARP Public Policy Institute, *Women and Long-Term Care* (April 2007).
[9] In 2004, 12% of women were unpaid caregivers for a family member who was chronically ill, disabled, or elderly, compared to 8% of men. *Women and Health Care*, supra note 1.
[10] Protections are in effect for health plan years beginning *on or after* this date, e.g. if your existing insurance plan is renewed on July 2014, 2011, the new provisions take effect at that time. Some health plans have announced that they will voluntarily implement certain provisions earlier than required.
[11] "Mental Health Care Utilization," supra note 2.