



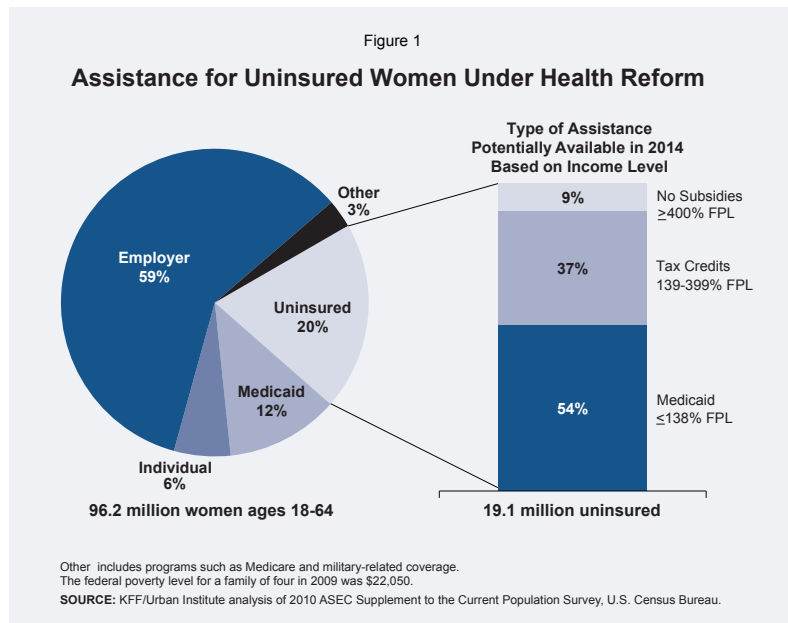
Impact of Health Reform on Women’s Access to Coverage and Care

Introduction

The new health reform law, the Patient Protection and Affordable Care Act (ACA) was signed by President Obama on March 23rd, 2010. This new law holds the potential to expand women’s access to health insurance coverage and make other reforms that may strengthen the existing health care system’s ability to serve millions of women. Health care has long been a fundamental policy priority for women, reflecting their experiences with the health care system as patients, mothers, and caregivers for frail and disabled family members. This brief discusses the impact of the new reform law for women on their access to coverage, health care affordability, scope of benefits, reproductive health, and long-term care— all priority issues for women. Many of the important details that will shape how well the law improves coverage rates for women and ultimately, access to care, will depend on the regulations that will be promulgated by the Department of Health and Human Services, the choices that state policy makers will make regarding their Medicaid programs and new insurance exchanges, and in the end, the types of plans that are selected by women and their families.

Impact on Coverage

One of the major goals of the health reform law is to expand access to coverage to the uninsured, and the ACA requires almost all individuals to have some form of health coverage by 2014. The new law accomplishes this by creating a system where nearly all individuals can obtain some form of insurance (Table 1). Major changes include: expanding eligibility for the public Medicaid program for many more low-income people, requiring larger employers to provide coverage to workers and their dependents or pay an annual fee, establishing tax credits and other incentives for smaller employers to cover their employees, and establishing new state-based “exchanges,” through which all citizens can purchase insurance if they do not have another form of coverage.



Employer-Sponsored Insurance: Today most women and men in the U.S. are covered by insurance obtained through the work place (Figure 1). There are differences between coverage patterns, however, that can leave women exposed to losing coverage. Because women with employer-based insurance are almost twice as likely as men to be covered as dependents, they can be more vulnerable to losing their insurance should they become widowed, divorced or if their husbands lose their jobs.¹

Only half of working women are able to get health coverage through their jobs compared to 57% of men.² Affordability of care is a key issue for women who are disproportionately low-income. Out-of-pocket costs take many forms, including premiums, co-payments, and insurance plan spending caps on coverage. Women are consistently more like than men to report a wide range of cost-related barriers to care for themselves and their families (Figure 2). Premiums are a major cost for both employers and employees, and have risen 27% since 2005. These costs have been particularly unaffordable for small employers, who have less bargaining power with insurers and are less likely to offer coverage to their employees.³

Table 1: Summary of Selected Coverage and Benefits Provisions Affecting Women in the Patient Protection and Affordable Care Act (P.L. 111-148)

<p>Expanding coverage</p>	<ul style="list-style-type: none"> • Uninsured individuals with incomes up to 138% of federal poverty level (\$25,267 for a family of three) will qualify for Medicaid. • Those with incomes between 139% and 399% of poverty can purchase insurance through state exchanges and receive tax credits to subsidize premium costs. • Larger employers must offer coverage to workers or pay a penalty; tax credits for certain small employers who offer coverage. • U.S. citizens and legal residents required to have qualifying health coverage or pay a penalty. • Exemptions for financial hardship, religious objections, American Indians, those uninsured less than 3 months, undocumented immigrants, incarcerated individuals, if plan cost exceeds 8% of income, if income is below tax filing threshold.
<p>Insurance reforms</p>	<ul style="list-style-type: none"> • Requires guarantee issue and renewability of policies (regardless of health status). • Prohibits higher premium charges based on gender, health status, or occupation; allows variations in premiums based on age (3 to 1) and tobacco use (1.5 to 1) only. • Bans pre-existing condition exclusions and prohibits annual and lifetime limits on coverage.
<p>Benefits</p>	<ul style="list-style-type: none"> • Essential health benefits: Requires new plans to offer minimum coverage, referred to as essential health benefits. This benefit package will include the following categories of services: Ambulatory care, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and chronic disease management. • Preventive care: Eliminates cost-sharing for U.S. Preventive Services Task Force (USPSTF) recommended services and Advisory Committee on Immunization Practices recommended immunizations in qualified health plans (in 2010) and Medicare (by 2011). Financial incentives (no requirement) for Medicaid to cover these services without cost-sharing. Additional women’s preventive care and screening services will also be identified for coverage. • Maternity care: Maternity and newborn care included as essential benefit in plans; requires Medicaid coverage of tobacco cessation supports for pregnant women; new grants to states for home visiting and postpartum depression services; new workplace protections for nursing mothers (break time and private space to express milk) • Family planning and teen pregnancy prevention: Contraceptives not included in essential package; states can establish Medicaid family planning programs without federal permission; provides \$75 million/year to states for evidence based sex education programs; and restores \$50 million/year for abstinence-unless-married educational programs. • Abortion: Bans any federal subsidies from being used to purchase coverage for abortion beyond federal limits (to save the life of the woman and in cases of rape and incest); at least one plan within a state exchange must limit abortion coverage to only those permitted by federal law; excluded from essential benefit list, and states can prohibit abortion coverage in their exchange; New state Pre-existing Condition Insurance Plans cannot cover abortions beyond those permitted by federal law.
<p>Medicare</p>	<ul style="list-style-type: none"> • Eliminates cost-sharing for USPSTF recommended services starting in 2011; new personalized health plan benefit with an annual comprehensive risk assessment. • Enrollees will receive a \$250 rebate if they have any spending in the coverage gap (doughnut hole) and will be eligible for a new phased in discount program to reduce costs of brand name and generic drugs. Reduces the prescription drug coinsurance rate to 25% of costs by 2020.
<p>Long-term care</p>	<ul style="list-style-type: none"> • Establishes the CLASS Act by 2011, a voluntary savings program to provide cash benefit to those with disabilities to purchase non-medical services and supports; adults can contribute through payroll deductions or directly.
<p>Women’s health</p>	<ul style="list-style-type: none"> • Codifies the establishment of Offices on Women’s Health in major federal agencies, including DHHS, CDC, FDA, HRSA, and AHRQ; Establishes a DHHS Coordinating Committee on Women’s Health and a National Women’s Health Information Center.

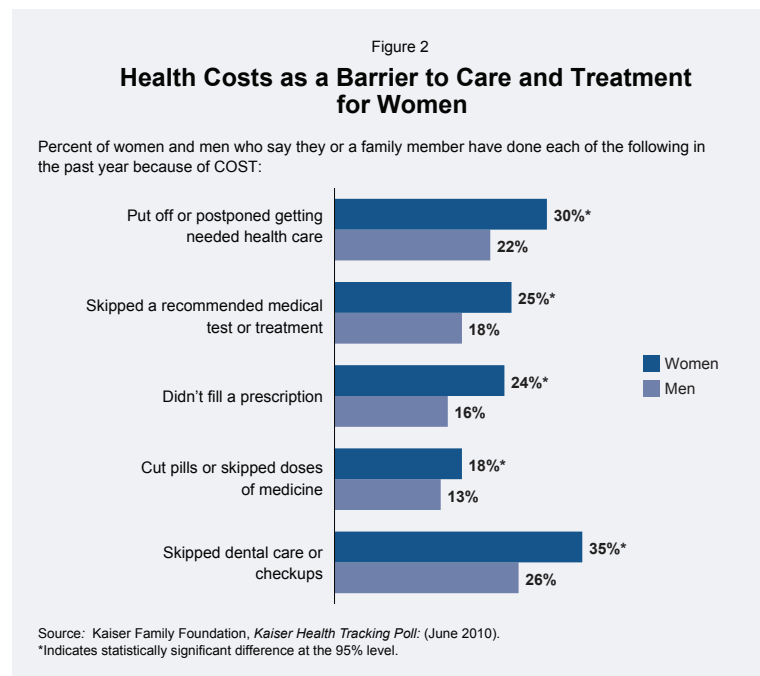
The new law will allow individuals who currently have insurance to keep the coverage they have. Large employers (more than 50 employees) will be required to offer coverage to their employees or pay a monetary penalty. Small employers (50 or fewer employees) will be exempt from these penalties. To encourage small employers to offer coverage and help address their affordability concerns, employers with 25 or fewer employees that do cover their employees will receive tax credits to help offset the insurance costs.

Health Insurance Exchange: Small businesses and uninsured individuals will be able to purchase coverage from a choice of private or public plans that will be sold through new entities: state-level health insurance “exchanges,” a marketplace of health plans that will be required to cover a minimum set of services. Premiums in these exchange plans will be set using a modified community rating, so that insurers will be prohibited from charging higher premiums based on sex, health status, or occupation. Premiums will only be allowed to vary by age (3 to 1) and tobacco use (1.5 to 1).

In addition to the changes in premium pricing, the law has other provisions to make insurance more affordable for individuals and small employers seeking coverage in exchanges. Individuals and families with incomes between 139% and 399% of the federal poverty level (in 2010, \$88,000 for a family of four) will be eligible for a graduated system of subsidies or tax credits (that will vary by income) that they can use towards the cost of insurance premiums. An estimated four in 10 currently uninsured adult women (37%) will qualify for these tax credits based on their household income (Figure 1). Cost-sharing subsidies will also be available for individuals with household incomes between 100–250% of the federal poverty level (FPL) and there will be caps on out-of-pocket costs to reduce financial burdens on these low-income families. The availability of these new subsidies combined with a major expansion in Medicaid means that in all states, the majority of currently uninsured women will receive some form of federal financial assistance to obtain coverage in 2014 as a result of the health reform law.

Individual Market: Currently, about six percent of women purchase coverage through the individual insurance market. Historically, these plans have been able to deny coverage to individuals with a “preexisting condition” such as pregnancy, mental illness, or a chronic condition. They have also been able to refuse to renew coverage for individuals with health problems or raise the premium rates to levels that are unaffordable to many policy holders. Furthermore, in many states, insurers have been able to charge women who purchase individual insurance more than men for the same coverage, a practice called gender rating.⁴ Yet, plans sold on the individual market often do not cover many important services for women, such as maternity care, mental health, and prescription drugs.⁵

The ACA makes many changes to this market. It subjects new individual insurance market plans to the same regulations as plans sold in state-based exchanges. Therefore, it will ban the practices of gender rating, pre-existing condition exclusions, and varying premiums based on health status in the individual market starting in 2014. Furthermore, all plans sold on the individual market will have to cover a minimum level of services, which includes maternity care. While people will be able to continue to buy coverage through the individual insurance market subject to these changes, it is expected that many who currently purchase insurance on their own will seek coverage in plans within state exchanges where they will be able to get subsidies should they qualify.



Medicaid: The Medicaid program, the state-federal program for low-income people, has historically served as a critical safety-net for low-income mothers and pregnant women. Today, 12% of women are covered under Medicaid, and women comprise over two-thirds of adult Medicaid beneficiaries.⁶ Historically, women have been more likely than men to qualify for Medicaid because, on average, women have lower incomes and they are also more likely to fall into one of the program's eligibility categories: pregnancy, parent of dependent child, over 65, or disability.

The new health reform law eliminates these restrictive "categorical" requirements and bases eligibility solely on income, effectively expanding Medicaid eligibility to all individuals with incomes up to 138% of FPL.⁷ In 2009, just over half of uninsured women (54%) had incomes less than 138% of the federal poverty level, and many of these women will likely qualify for Medicaid after the new law is in force in 2014 (Figure 1). This expansion opens the door for coverage to adults without children who typically have not been able to qualify for Medicaid, no matter how poor they are. States will continue to operate Medicaid programs under federal guidelines, and the federal government will finance the bulk of the costs of the expansion for several years, gradually increasing states' share (Table 3).

Exemptions and Timeline: The law does exempt certain populations from the coverage mandate, including American Indians, undocumented immigrants, individuals with incomes below tax filing threshold, and if the cost of coverage exceeds 8% of income. There are also exemptions for those with financial hardship or religious objections. Since 1996, legal immigrants have been barred from Medicaid and CHIP during their first five years in the U.S. States do have the option to eliminate this five-year ban for pregnant women or children, but this has not been widely adopted. As a result, most legal immigrants still will not qualify for Medicaid for at least five years,⁸ although they will be eligible for premium subsidies in the new exchanges if they meet the income requirements. Undocumented immigrants will not be allowed to purchase coverage within state exchanges, even by paying full cost out-of-pocket. They may have access to individual insurance plans sold outside of exchanges.

While most of the insurance coverage changes will take effect in 2014, some changes have already gone into effect. Most notably, plans are now required to allow policyholders to extend dependent coverage to individuals up to age 26, regardless of whether they are students or married. This extends a coverage option to an age group that has among the highest rates of being uninsured. Currently, 29% of women between the ages of 19 and 25 are uninsured (4.2 million women) and could potentially benefit from this expansion.⁹ In addition, the federal government will provide states with financial assistance to establish high risk pools to extend coverage to those who are uninsured and considered uninsurable because of health problems. These pools will be in effect until 2014 when exchanges and Medicaid expansions will be in force.

Benefits and Access to Care

For the first time, the new law specifies a minimum package of services that must be offered for those obtaining coverage from qualified plans in the individual market, small group market, as well as the state exchanges. These benefits are referred to as the "essential health benefits" and broadly include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, including behavioral health treatments, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services including oral and vision care. Exact details about the type and scope of coverage are to be specified by the Secretary of Health Human Services one year after the passage of the bill (March 2011). For those newly eligible for Medicaid, states will be required to either offer them coverage through their existing Medicaid programs or an alternative "benchmark" benefit package that must include at least the essential health benefit package offered by plans in the exchanges.

Primary Care: The importance of primary care in identifying and managing chronic health problems and improving use of preventive services is well established.¹⁰ Yet, there has been a long-standing shortage of primary care providers, particularly physicians, for adults.¹¹ The new law includes numerous payment incentives to draw more primary care providers to the health care workforce. This includes a 10% bonus in Medicare payment rates for primary care physicians, the ability to choose a Certified Nurse Midwife as a primary care provider, a

temporary increase in Medicaid primary care payment rates, and policies that will promote coordinated primary care for high need individuals who are dually eligible for Medicaid and Medicare. Nearly two-thirds (63%) of this dually eligible population are women.¹² In addition, the new law includes a provision that permits women in group health plans to have direct access to participating ob-gyns without needing a primary care provider referral.

Preventive Care: The health reform law includes some important new expansions in the coverage of preventive services that begin to take effect in 2010. Individuals covered through new small and large group plans, new individual insurance policies, and under Medicare by 2011 will have coverage—without cost-sharing—for preventive services that are deemed “highly effective” by the U.S. Preventive Services Task Force (USPSTF) with an A or B rating (Table 2). The USPSTF is an independent body that reviews the evidence and rates the efficacy of preventive services in a primary care setting. In the case of mammography, all qualified health plans will need to cover annual mammography for women starting at age 40. For immunizations, those recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention will be required by law to be covered without cost-sharing. For women and girls under 26, this will mean that the HPV vaccine must be covered free of cost sharing (no copays, deductibles, or co-insurance can be applied). The new law will also cover additional women’s preventive care and screening services to be established by the Health Resources and Services Administration (HRSA) that are not included in the USPSTF recommendations. A panel of experts will be convened to review the evidence on other preventive services for women in order to make recommendations to HRSA regarding which preventive services should be included. Some of the services that advocates have suggested be considered for this benefit include family planning, periodic “well woman” visits, preconception counseling, and domestic violence screening for women. Over time, coverage of these preventive benefits will be extended to individuals in the private market (group and individual), the exchanges, as well as Medicare. Although there are no requirements for Medicaid to cover these preventive services without cost-sharing, there are financial incentives for the states to do so in the form of an enhanced federal payment match.

Table 2: Selected U.S. Preventive Services Taskforce A and B Level Recommendations Important to Women

Early Cancer Detection	STI/STDs Screening and Treatment	Prevention and Management of Chronic Conditions	Pregnancy Related Intervention	Lifestyle/Healthy Behaviors
Colorectal screening for adults ages 50–75	HIV screening for all adolescents and adults at high risk	Hypertension screening for all adults	Tobacco use counseling and interventions	Alcohol screening and counseling in adults
Breast cancer screening (mammography at age 40 every 1–2 years)	Gonorrhea screening for all sexually active women at increased risk	Diabetes screening for adults with elevated blood pressure	Breastfeeding counseling	Depression screening when supports are available
Breast cancer chemoprevention counseling for high-risk women	Chlamydia screening for sexually active women 24 and younger	Aspirin to prevent cardiovascular disease for women age 55–79, balancing risks and benefits	Hepatitis B screening	Healthy diet counseling for cardiovascular and other high risk patients
Breast/ovarian cancer genetic counseling referral for high risk women (for BRCA screening)	Syphilis screening for women at increased risk (all pregnant women)	Osteoporosis screening for all women 65 and older and at age 60 for high-risk women	Iron deficiency anemia screening	Tobacco use counseling and interventions
Cervical cancer screening for sexually active women with a cervix	STI counseling for all sexually active teens and adults at increased risk	Cholesterol screening for women at age 45; starting at 20 for those at high risk	Bacteriurea screening	Obesity screening, counseling and behavioral interventions for obese adults

Source: Adapted from USPSTF A and B Recommendations. August 2010. U.S. Preventive Services Task Force. <http://uspreventiveservicestaskforce.org/uspsf/uspsabrecs.htm>.

Maternity Care: Childbirth and pregnancy-related conditions are leading causes of hospitalization in the U.S., accounting for nearly 25% of hospital stays.¹³ Although the Pregnancy Discrimination Act requires that employers with at least 15 employees offer plans that cover expenses for pregnancy-related conditions on the same basis as for other medical conditions, coverage for maternity care is not included in many individual insurance plans currently. In this market, women typically have had to purchase a separate rider to cover maternity care which can be extremely costly and often requires a waiting period before the benefits are covered. As stated earlier, the health reform law explicitly identifies maternity and well-baby care as part of the essential benefits package that must be offered by plans in the Exchanges and new plans offered in the individual and small group markets. The details on the particular maternity services that insurers will be required to cover will be specified by the Secretary of Health and Human Services by March 2011.

For the millions of women who will now qualify for Medicaid, all state Medicaid programs already cover pregnancy related care up to at least 60 days post-partum, and in fact, Medicaid currently covers 41% of all births nationwide.¹⁴ Many women, however, lose Medicaid coverage after the post-partum period because they no longer qualify for coverage because income eligibility levels for parents are considerably more restrictive than those for pregnant women.¹⁵ The new law will help low-income new mothers maintain their coverage throughout pregnancy and beyond. The new law also makes some important improvements to Medicaid coverage of maternity care and childbirth, requiring coverage of comprehensive tobacco cessation programs for pregnant women on Medicaid and increased support for reimbursement of nurse midwives, birth attendants, and free-standing birth centers. In addition, all newborns lacking any other acceptable coverage will be eligible for Medicaid.

The law also includes a number of other new benefits for pregnant women and new mothers, including education and support services to women with postpartum depression as well as funding for research into the causes, diagnoses, and treatments of post-partum depression. There are new investments in maternal, infant and early childhood home visiting programs that will require states to conduct assessments of family and community health needs and provide grants to provide services to high-risk families. The law increases reimbursement under Medicare to pay nurse midwives at 100% of the reimbursement rates of physicians. While Medicare covers few births, its payment schedule is used by many insurers. The health reform law also amends the Fair Labor Standards Act to require employers with at least 50 employees to provide a break time to nursing mothers for up to one year after the child's birth as well as a private space that is not a bathroom to express milk. By providing workplace protections, this new rule has the potential to improve breastfeeding rates for new moms returning to the workplace.

Family Planning and Teen Pregnancy Prevention: Contraception is one of the most widely used services among women. Most workers in employer-sponsored plans are currently covered for contraceptives.¹⁶ Family planning counseling and contraceptive devices, however, unlike maternity care are not specifically named as an essential benefit that must be covered by plans within an exchange. Whether family planning services will be deemed an essential benefit and/or a preventive service exempt from cost-sharing is likely to be a major topic of discussion as the scope of covered services is detailed in the coming years.

Medicaid, in contrast, already requires that states cover family planning services without cost-sharing, and the federal government provides an enhanced matching rate to states for these services. The new law specifies that states that decide to offer newly eligible Medicaid enrollees a benchmark benefit plan must include coverage of family planning services to all qualifying individuals. Additionally, about half of states currently have limited-scope Medicaid programs that provide coverage for family planning benefits (contraceptive devices, medical visits, and STI screening services) for individuals who do not qualify for full Medicaid coverage.¹⁷ This program, however, has required that states receive special permission from the federal government to operate these family planning programs—a complicated and time-consuming process for state officials. The new law will now allow states to extend eligibility for family planning services to those with incomes below 185% of poverty without going through the process of filing for federal permission (some states can set higher income thresholds). States will be able to do this by changing their own Medicaid rules through a state plan amendment to their Medicaid program.

The new law also provides funding (\$75 million/year) for a new program, the State Personal Responsibility Education Program (PREP), for states to provide evidence based sex education to reduce teen pregnancy rates and the incidence of sexually transmitted infections. Screening for HIV, chlamydia, gonorrhea and syphilis are included in current USPSTF recommendations for certain populations, especially high-risk youth, and therefore will be covered without cost-sharing for those getting coverage in the exchange and qualified plans, and eventually, in most private plans. The new law also restores \$50 million a year for five years in funding for the State Title V Abstinence Education Grant Program which expired in 2009 and was originally authorized in the 1996 welfare reform law. This program supports state program that promote “abstinence unless married” education, a program that has been highly controversial.

Abortion: The health reform law outlines specific provisions regarding coverage for abortions. Under current law, the federal Hyde Amendment limits the use of federal funds for abortion only to cases when the pregnancy is a result of rape or incest or is a threat to the woman’s life. This rule limits abortion coverage for federal employees, Medicaid enrollees, the Indian Health Service, and women in the military, and will remain in force under health reform. Furthermore, abortion coverage is specifically banned from being required as part of the essential benefits package offered by plans in exchanges and all of the exchanges must offer consumers the choice of at least one plan that does not provide abortion coverage. States may also enact legislation that bans any plan from offering abortion coverage, either in the exchange or more broadly in the private market and several states either have laws or are pressing forward with new laws that do that.¹⁸ Plans participating in the exchanges may not discriminate against any provider because of an unwillingness to provide, pay for, cover, or refer for abortions.

In states that will have exchange plans that cover abortion, federal subsidy dollars will be limited to covering abortions only when the pregnancy endangers the life of the woman, or is the result of rape or incest, consistent with the current Hyde Amendment. Coverage for other abortions can be paid for with private, state or local funds. To ensure that federal funds are not used for abortion coverage, plans that do cover abortions beyond Hyde limitations must segregate funds and estimate the actuarial value of such coverage by taking into account the cost of the abortion benefit. This separate premium must be charged of all individuals who enroll in the plan (including men and women of all ages). For women on Medicaid, the state rules for Medicaid coverage will be in effect. Currently, 17 states go beyond the federal limits on abortion coverage and offer coverage for other medically necessary abortions with state-only funds.¹⁹

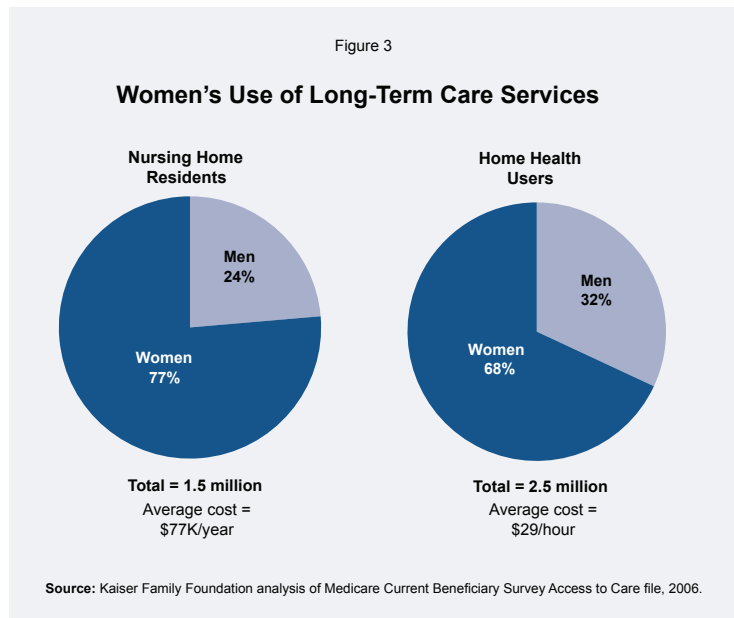
Coverage for Older Women and Women with Disabilities

Medicare: Accounting for 56% of all Medicare beneficiaries, women on Medicare have significant health needs and on average live longer and experience higher rates of many chronic health conditions than men.²⁰ However, the program has relatively high cost-sharing requirements, which can be prohibitive for many seniors, particularly for older women, who have fewer financial resources than their male counterparts. In addition to affordability challenges, the Medicare program has had some notable gaps in coverage for long-term care, prescription drugs, and essential services such as vision and dental care. Furthermore, some preventive benefits important to older women’s health, such as mammography, clinical breast exams, bone density tests, and visits for Pap test and pelvic exams, have required 20% coinsurance which can serve as a barrier to getting these recommended services.²¹

The new law makes several changes to Medicare that should ease some of the out-of-pocket costs beneficiaries have had to incur for drugs and preventive services. As discussed earlier, starting in 2011, Medicare beneficiaries will no longer have to pay any cost-sharing for all preventive services that the USPSTF has rated A or B which includes mammograms, pap smears, and bone density screenings (Table 2). In addition, all Medicare beneficiaries will be eligible to receive a personalized health plan that includes an annual comprehensive risk assessment. Prescription drug coverage is also a critically important issue for women on Medicare. The law makes some important changes to reduce the spending gap found in prescription drug coverage, called the “doughnut hole.” By 2020, the coinsurance rate will be 25% of costs, down from 100% of costs today.²² Starting in 2010, enrollees will receive a \$250 rebate if they have any spending in the coverage gap. There will also be a phased-in discount program to reduce costs of both brand name and generic drugs for Medicare beneficiaries.

Long-term care: For frail and elderly women and their families, long-term care is a crucial concern. Women are more likely than men to both need long-term care services and to lack the social supports and resources needed to live independently in the community.²³ As a result, women comprise the majority of nursing home residents and home health users (Figure 3). Women who need long-term care services often pay sizable out-of-pocket costs for nursing home and community based care, as a result of the limited coverage for long-term care under both Medicare and private policies.²⁴

The health reform law offers some assistance with long-term care costs via the Community Living Assistance Services and Support (CLASS) Act. This is a new voluntary insurance program that working adults can purchase by making contributions via payroll deductions through their employer or on their own. All working adults will be automatically enrolled in the program unless they opt out. Adults in need of long term care (such as those with limitations in daily activities or cognitive impairments) will be eligible for cash benefits if they have paid monthly premiums for at least five years and have been employed during three of those five years. The benefit is based on the degree of impairment or disability, averaging no less than \$50 per day, and can be used to purchase non-medical services and supports, such as home health assistance or transportation, to help them remain independent and stay in their communities.²⁵



Federal Offices on Women's Health

The new law codifies the establishment of Offices on Women's Health in major federal agencies, including Department of Health and Human Services, Centers for Disease Control and Prevention, the Food and Drug Administration, Health Resources and Services Administration, and an office of Women's Health and Gender-Based Research at the Agency for Healthcare Research and Quality. These offices are designed to establish goals, provide information on women's health activities, and identify women's health priorities within their respective agencies. It also authorizes the establishment of a Department of Health and Human Services Coordinating Committee on Women's Health to coordinate the activities of these offices as well as a National Women's Health Information Center to facilitate exchange of information regarding health promotion, prevention, major advances in research, and other relevant developments in women's health. While many of these offices already exist, the new law offers additional protection by prohibiting termination, reorganization, or transfers of powers and responsibilities of the offices or other appointed positions with primary responsibility over women's health issues without the direct approval of Congress.

Conclusion

The new law will offer many opportunities to improve access to care and coverage for women of all ages, ranging from insurance system reforms, to lowering out-of-pocket costs, and securing comprehensive benefits packages that address women's health needs across the course of their lives. These issues are essential to women's ability to obtain timely, appropriate care and preventive services. Women were clearly a key constituency in passing the health reform law and as the implementation process moves forward, women will continue to play a large role in shaping critical decisions at the federal, state and plan level.

Table 3: State Level Estimates of Percent of Uninsured Women Ages 18-64 Likely to Qualify for Federal Assistance Under the Patient Protection and Affordable Care Act

	Total Number of Women Ages 18-64 in State	Total Number of Uninsured Women 2008-2009	Percent of Total Women in State	Percent of Currently Uninsured Women Ages 18-64 Potentially Eligible for Federal Assistance in 2014	
				Likely to Qualify for Medicaid*	Likely to Qualify for Premium Credits in the Exchanges**
Alabama	1,477,632	267,432	18%	59%	33%
Alaska	213,764	46,193	22%	47%	43%
Arizona	2,001,195	423,920	21%	55%	34%
Arkansas	893,971	220,534	25%	58%	37%
California	11,468,537	2,600,750	23%	54%	38%
Colorado	1,597,846	284,628	18%	50%	39%
Connecticut	1,117,863	133,786	12%	43%	42%
Delaware	272,261	36,419	13%	46%	42%
District of Columbia	215,670	22,325	10%	54%	36%
Florida	5,647,972	1,471,634	26%	50%	39%
Georgia	3,179,335	718,551	23%	59%	34%
Hawaii	374,294	35,931	10%	58%	31%
Idaho	458,619	90,987	20%	53%	41%
Illinois	4,067,949	650,535	16%	49%	41%
Indiana	1,926,666	335,806	17%	56%	38%
Iowa	943,002	122,338	13%	50%	41%
Kansas	852,760	128,258	15%	60%	33%
Kentucky	1,360,040	283,263	21%	60%	34%
Louisiana	1,401,170	332,667	24%	57%	36%
Maine	421,306	52,064	12%	37%	47%
Maryland	1,854,535	269,809	15%	50%	41%
Massachusetts	2,122,424	110,448	5%	--	--
Michigan	3,167,068	506,060	16%	53%	37%
Minnesota	1,635,514	161,700	10%	41%	49%
Mississippi	892,627	192,468	22%	60%	33%
Missouri	1,858,561	315,604	17%	51%	42%
Montana	294,264	56,003	19%	47%	41%
Nebraska	552,903	73,125	13%	47%	46%
Nevada	802,449	182,387	23%	52%	39%
New Hampshire	430,344	53,147	12%	38%	46%
New Jersey	2,736,818	475,895	17%	47%	39%
New Mexico	612,835	168,700	28%	56%	32%
New York	6,320,752	1,020,835	16%	47%	40%
North Carolina	2,929,470	587,208	20%	59%	34%
North Dakota	200,963	24,747	12%	47%	44%
Ohio	3,636,701	581,200	16%	53%	40%
Oklahoma	1,112,305	229,265	21%	49%	41%
Oregon	1,205,367	227,828	19%	53%	39%
Pennsylvania	3,892,432	471,961	12%	50%	40%
Rhode Island	342,475	45,742	13%	52%	39%
South Carolina	1,426,376	274,335	19%	56%	35%
South Dakota	245,913	40,366	16%	50%	39%
Tennessee	1,954,338	356,929	18%	52%	42%
Texas	7,556,599	2,333,886	31%	54%	38%
Utah	822,431	133,266	16%	48%	36%
Vermont	205,952	20,408	10%	32%	49%
Virginia	2,498,121	375,355	15%	47%	43%
Washington	2,130,019	300,250	14%	48%	43%
West Virginia	554,410	114,953	21%	55%	36%
Wisconsin	1,725,777	171,483	10%	49%	42%
Wyoming	161,613	30,332	19%	42%	44%

Notes: The federal poverty level (FPL) for a family of four in 2009 was \$22,050.

* Percent of women ages 15-44 who are currently uninsured with incomes \leq 138% of the federal poverty level.

** Percent of women ages 15-44 who are currently uninsured with incomes 139-399% of the federal poverty level.

-- Sample size insufficient to make reliable estimate.

Source: Kaiser Family Foundation/Urban Institute estimates of ASEC supplement to March 2009 and March 2010 Current Population Surveys, U.S. Census Bureau.

ENDNOTES

- ¹ Kaiser Family Foundation, Women's Health Insurance Coverage Factsheet, October 2009.
- ² Roadblocks to Health Care: Why the Current Health Care System Does Not Work for Women, Office of Health Reform, Department of Health and Human Services, 2009.
- ³ Kaiser Family Foundation, Employer Health Benefits 2010 Annual Survey, 2010.
- ⁴ National Women's Law Center, Nowhere to Turn: How the Individual Health Insurance Market Fails Women, September 2008.
- ⁵ Committee on Energy and Commerce, U.S. House of Representatives, "Memorandum on Maternity Coverage in the Individual Health Insurance Market," October 12, 2010.
- ⁶ Kaiser Family Foundation analysis of the March 2010 Current Population Survey, U.S. Bureau of the Census.
- ⁷ Legislation extends Medicaid coverage to all individuals with incomes up to 133% of the poverty level (FPL) and includes a provision to disregard first 5% of income, effectively extending Medicaid to all individuals with incomes up to 138% FPL.
- ⁸ Kaiser Commission on Medicaid and the Uninsured. "State Children's Health Insurance Program Reauthorization Act", 2009.
- ⁹ Kaiser Family Foundation analysis of the March 2010 Current Population Survey, U.S. Bureau of the Census.
- ¹⁰ Starfield, Barbara. "Refocusing the system" *New England Journal of Medicine* 359;20. 2008.
- ¹¹ Council on Graduate Medical Education, New Paradigms for Physician Training for Improving Access to Health Care, September 2007.
- ¹² Kaiser Family Foundation, Where Does the Burden Lie?: Medicaid and Medicare Spending for Dual Eligible Beneficiaries, April 2009.
- ¹³ Estimate based on AHRQ, Care of Women in U.S. Hospitals, 2000: HCUP Fact Book No. 3, September 2002.
- ¹⁴ Kaiser Family Foundation, Medicaid's Role for Women, November 2007.
- ¹⁵ Kaiser Family Foundation, Medicaid's Role for Women, November 2007.
- ¹⁶ Kaiser/HRET, 2010 Annual Employer Health Benefits Survey, September 2010.
- ¹⁷ Guttmacher Institute, "State Medicaid Family Planning Eligibility Expansions, *State Policies in Brief*, October 2010.
- ¹⁸ Center for Reproductive Rights. "Abortion Access: Restrictions on Public Funding and Insurance Coverage. 2009.
- ¹⁹ Guttmacher Institute, *State Policies in Brief*, October 2010.
- ²⁰ Kaiser Family Foundation, Medicare's Role for Women, 2009.
- ²¹ Trivedi, A. "Effect of Cost Sharing on Screening Mammography in Medicare Health Plans" *New England Journal of Medicine*; 358:357-383. 2008.
- ²² Kaiser Family Foundation. Health Reform: An Overview. October 2010.
- ²³ Salganicoff A, et al. "Health Coverage and Expenses: Impact on Older Women's Economic Well-Being," *Journal of Women, Politics, and Policy*, 2009.
- ²⁴ Kaiser Family Foundation, Medicare's Role for Women, 2009.
- ²⁵ Kaiser Family Foundation, Health Care Reform and the CLASS Act, April 2010.

This publication (#7987) is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800
Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274

The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.