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Women's Health Coverage Since the ACA: Improvements for Most, But Insurer Exclusions Put Many at Risk

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ABSTRACT

Issue: Since enactment of the Affordable Care Act (ACA), many more women have health insurance than before the law, in part because it prohibits insurer practices that discriminate against women. However, gaps in women's health coverage persist. Insurers often exclude health services that women are likely to need, leaving women vulnerable to higher costs and denied claims that threaten their economic security and physical health. **Goal:** To uncover the types and incidence of insurer exclusions that may disproportionately affect women's coverage. **Method:** The authors examined qualified health plans from 109 insurers across 16 states for 2014, 2015, or both years. **Key findings and conclusions:** Six types of services are frequently excluded from insurance coverage: treatment of conditions resulting from noncovered services, maintenance therapy, genetic testing, fetal reduction surgery, treatment of self-inflicted conditions, and preventive services not covered by law. Policy change recommendations include prohibiting variations within states' "essential health benefits" benchmark plans and requiring transparency and simplified language in plan documents.

BACKGROUND

The Affordable Care Act (ACA) changed the landscape of the individual health insurance market for women. Before its full implementation, women were routinely charged higher premiums than men, prevented from purchasing coverage for services they needed, or denied coverage altogether. Insurers regularly denied coverage for a range of "preexisting conditions": being pregnant, having undergone a Cesarean section, and even receiving health services after sexual assault.[1] Women commonly paid more than men for their insurance, at an additional cost of approximately $1 billion per year, and many plans excluded maternity coverage.[2,3] Such discriminatory practices led women to bear significant costs for health insurance or to forgo care altogether.[4]

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Because of the ACA's rules, insurers can no longer deny coverage or charge higher premiums because of gender or because of current or prior health conditions (Exhibit 1). All individual market plans must cover essential health benefits that include maternity services, birth control, mammograms and other preventive care, and mental health services.

Exhibit 1

Improvements in Individual Market Health Insurance That Benefit Women

Plans cannot:	Plans must:
Base premiums on gender	Provide preventive services, including birth control, breastfeeding support and supplies, and mammograms, without cost-sharing to eligible women
Vary premiums based on health conditions	Cover essential health benefits, including maternity services, mental health, and prescription drugs
Discriminate based on sex	Cover any eligible enrollee
Deny coverage because of a preexisting condition or exclude services to treat a preexisting condition	

However, there are still insurance practices that can leave women without adequate coverage. One such practice is the exclusion of certain services from plan coverage.

In this brief, we present results from our analysis of exclusions in qualified health plans (QHPs) from 109 insurers in 16 states. We identify six categories, and numerous examples, of exclusions that may prevent women from being covered for conditions that disproportionately affect them, or for services they access—even those that are also available to men. Such exclusions can undermine a primary goal of the ACA: to improve women's health and eliminate gender discrimination in health insurance markets.

The service exclusions we identify are often described in health plan materials for consumers in language that is difficult to understand for somebody with limited health literacy, and often they appear only in detailed plan documents that many consumers do not read. As a result, women purchasing insurance may be unaware of this practice and the effect it may have on their coverage.

We review only exclusions described in QHPs' evidence of coverage, or similar documents; we do not address services excluded based on medical necessity determinations, medical policies, or other guidelines. Readers also should note that an insurer that excludes a particular service generally also excludes that service in all or most of the QHPs it offers within a state.

INSURER PLAN EXCLUSIONS THAT AFFECT WOMEN'S HEALTH

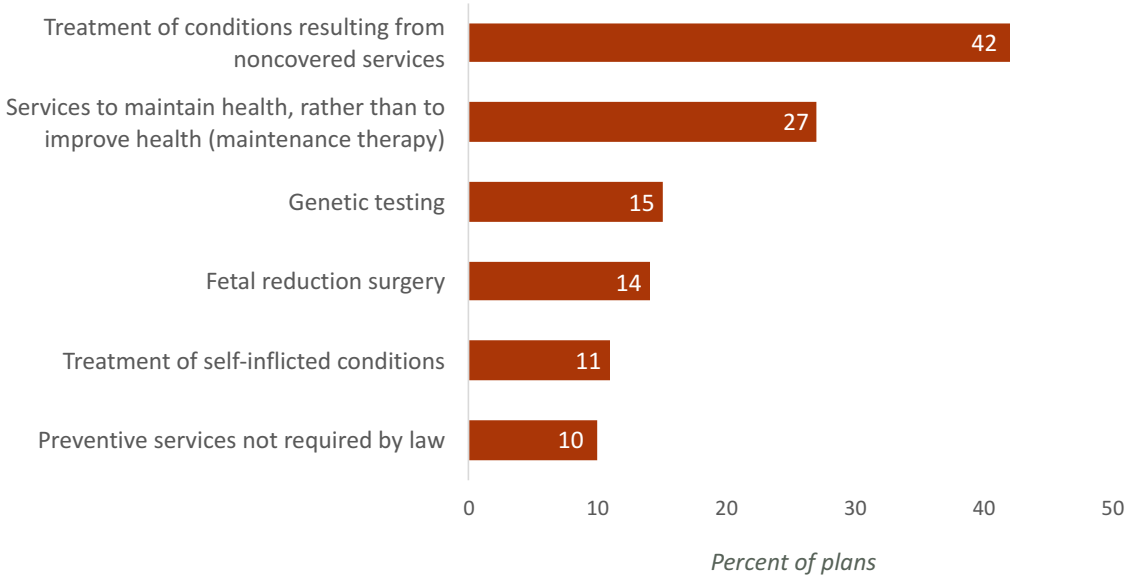
Conditions Resulting from Noncovered Services

Health insurers make determinations of medical necessity and formulate guidelines based in part on medical research—an area that tends to underrepresent women and their particular health needs.[5] As a result, women's health needs are not always incorporated into medical policies and guidelines informed by such research. Insurers also may deny a claim for needed medical care following the provision of an excluded service, such as treatment of an infection arising from a prophylactic

mastectomy. In our study, 46 of the 109 insurers examined exclude coverage of services that are related to, or arise from, other noncovered services (Exhibit 2 and Exhibit 3).

Exhibit 2

Incidence of Selected Exclusions in Plans Reviewed



Data: Authors' analysis.

Maintenance Therapy

Twenty-nine of the 109 insurers exclude coverage of maintenance therapy—treatments that maintain health but generally are not expected to lead to improvements—or exclude other ongoing medical treatments that "prevent regression of functions in conditions that are resolved or stable."[6] Nine of the 29 insurers omit both types of treatment. Women are more likely than men to have lupus, depression, chronic pain, and other chronic health conditions that require maintenance therapy.[7,8] They are also more likely to have breast and lung cancers, the two most common forms of cancer in women; these conditions also require maintenance therapy to prevent or slow their progression.[9,10]

Genetic Testing

Sixteen of the 109 insurers exclude coverage of genetic testing not expressly required by law. Women often rely on genetic testing to determine the need for prophylactic, or preventive, services. For example, genetic testing can reveal increased risk for breast or gynecological cancers; although many genetic mutations are connected with this greater risk, insurance plans are required to cover the testing of only two genes.[11]

For men and women who risk passing on serious genetic conditions, such as sickle cell disease or Tay-Sachs disease, to their child, preconception genetic counseling and testing are also common medical practice.[12] And women with various risk factors commonly receive prenatal genetic testing to help them make informed decisions about pregnancy and prepare for a child with health needs.[13]

Fetal Reduction Surgery

Fifteen of the 109 insurers exclude coverage for fetal reduction surgery, a service that may be recommended for a pregnant woman's health or to increase the chances of a successful pregnancy. Multifetal pregnancies carry numerous risks, including hypertension, preeclampsia, and postpartum hemorrhage,[14] and risks increase with the number of fetuses.[15] Only one insurer's exclusion for fetal reduction surgery contains an exception for medical necessity.[16]

Treatment for Self-Inflicted Injuries or Illnesses

Twelve of the 109 insurers exclude services for self-inflicted injuries or conditions. Because women are more likely than men to both attempt suicide and survive a suicide attempt, for example, such exclusions have a disproportionately harmful impact.[17] Women and their families often face the financial burden of large medical bills as a result. Moreover, plans do not define "self-inflicted," leaving the scope of the exclusions uncertain. An insurer might rely on this exclusion to, as an example, deny coverage of services to treat malnourishment resulting from an eating disorder, claiming that malnourishment is a self-inflicted condition. Four of the 12 insurers with self-inflicted exclusions have exceptions for injuries or conditions resulting from a physical or mental health condition such as anorexia or depression.[18] However, insurers may still deny claims for treatment if the provider does not list a diagnostic code for the underlying condition. This can be problematic for women with undiagnosed conditions, such as postpartum depression.[19]

Preventive Services Not Currently Required by Law

Eleven of the 109 insurers apply exclusions to prophylactic services. Prophylactic mastectomies and the removal of ovaries and fallopian tubes are widely considered appropriate procedures for women who have inherited particular genetic mutations or have a certain family or personal health history.[20] Antiretroviral prophylaxis is available for individuals exposed to HIV or other sexually transmitted diseases—particularly significant in the case of sexual assault.[21] The ACA requires coverage of a broad array of preventive services, but the list of services covered is based on those recommended for the general population, leaving out additional preventive services needed by many women (or other individuals with higher risk profiles).[22]

PROBLEMS FROM LACK OF TRANSPARENCY

There is little transparency in plan documents regarding health insurance exclusions. As a result, women may unwittingly enroll in plans containing exclusions that impact their coverage, and remain unaware of the exclusions until they seek services or have a claim denied. The short overview of coverage provided for each plan on the marketplace—called the "Summary of Benefits and Coverage"—includes space for information on exclusions. However, only 13 exclusions are required to be listed, and none of the exclusions described in this brief are in that group. Identifying all exclusions requires reading the underlying plan document, such as the evidence of coverage; yet some plan documents are over 100 pages long and exclusions appear in various sections. Terminology also varies among insurers; for example, some plans exclude "maintenance therapy" and others exclude "maintenance care." In addition, some exclusions appear among only a small number of insurers, so women cannot know all the exclusions to look for in their plans. For example, six insurers exclude services resulting from an enrollee's failure to comply with or accept recommended treatment, which is problematic for

women who are less likely than men to adhere to prescription protocols.[23] These factors make it difficult for women to identify and compare exclusions across plans.

POLICY RECOMMENDATIONS

The ACA has vastly improved health insurance coverage on the individual market for women. But coverage exclusions still impact women's access to health care and continue to impede federal efforts to improve women's health and eliminate gender discrimination in health insurance markets.[24] As discussed above, exclusions on maintenance therapy to manage chronic conditions, for example, can have the same effect as denying women coverage because of preexisting conditions, by excluding care for preexisting chronic conditions that are disproportionately prevalent in women. Regulators can address these problems through two approaches: prohibiting exclusions that undermine protections in the ACA and increasing transparency in their plans, so that women are aware of exclusions when choosing coverage.

Reduce Variability in State Requirements for Essential Health Benefits

ACA regulations require states to select a plan to use as a benchmark for the law's essential health benefits (EHB) requirements;[25] states that did not choose a benchmark plan were assigned a state-specific default plan that became the benchmark. However, insurers are allowed to offer benefit packages that substitute some benefits included in the benchmark plan for others, as long as the benefits are in the same category—such as hospitalization—and actuarially equivalent (meaning they provide the same level of coverage).[26] On the other hand, states may prohibit benefit substitution, which means that those states' QHPs must offer the same benefits as the benchmark.[27]

Both federal and state regulators can improve the EHB process to ensure that exclusions, like those identified in this brief, do not impede women's access to health care and coverage. Federal regulators could limit or prohibit exclusions through a number of regulatory strategies. For example, they could:

- prohibit benefit substitution in the EHB so that QHPs cannot contain any exclusions that do not exist in a state's benchmark plan
- ban specific exclusions in QHPs or plans offering the EHB
- clarify that an insurer is violating the EHB requirements if it selectively uses exclusions to prevent high-cost claims or encourage high-cost enrollees to drop coverage.

State regulators can limit exclusions through the following actions:

- prohibit substitutions in the EHB, allowing only those exclusions contained in the state's EHB benchmark plan, and reviewing compliance when approving plans
- require insurers whose plans contain exclusions that are not in the EHB benchmark to demonstrate that benefits are substantially similar to the benchmark, in compliance with federal regulations
- review plans for discriminatory exclusions and require insurers to revise these plans.

Ensure Transparency in Plan Documents

Plan summaries of benefits and coverage provide clear information to enrollees and potential enrollees about cost-sharing for certain services. However, because of a statutory page limit, they cannot describe all excluded services.[28] While summaries for QHPs must now include information about how enrollees can receive the evidence of coverage or contract, more can be done to improve transparency regarding plan exclusions.[29]

Online marketplaces can increase transparency using these strategies:

- require QHPs to provide a detailed list of exclusions
- post the complete list of exclusions on the marketplace website in a searchable format
- remind enrollees to review exclusions before completing enrollment.

The ACA has improved women's access to health coverage and care, yet exclusions create gaps in coverage that threaten their full access to health care and economic security. Regulators and insurers must take concrete steps to eliminate exclusions that disproportionately affect women, improve transparency in plan documents, and achieve the law's goal of ensuring that women can obtain the coverage and care they need.

Exhibit 3

Selected Exclusions by State and Insurer

State	Insurer	Year	Exclusion					
			Treatment of conditions resulting from noncovered services	Maintenance therapy	Genetic testing	Fetal reduction surgery	Treatment of self-inflicted conditions	Preventive services not required by law
Alabama	BlueCross BlueShield of Alabama	2015						
California	BlueShield of California	2015						
	Chinese Community Health Plan	2014, 2015						
	Contra Costa Health Plan	2014						
	Health Net (PPO)	2014						
	Health Net (HMO)	2014						
	Kaiser Permanente	2014						
	L.A. Care Covered	2014, 2015						
	Molina Healthcare	2014						
	Valley Health Plan	2014, 2015						
Colorado	Access Health Colorado	2014, 2015	X	X				
	All Savers Insurance, UnitedHealthcare	2014				X	X	X
	Anthem BlueCross BlueShield, HMO Colorado	2014, 2015						
	Anthem BlueCross BlueShield, HMO Colorado (multistate)	2014	X	X		X		
	Cigna	2014, 2015						
	Colorado Choice Health Plans	2014, 2015			X			
	Colorado Health Insurance Cooperative (EPO)	2015				X		
	Colorado Health Insurance Cooperative (PPO)	2014, 2015				X		
	Elevate by Denver Health Medical Plan	2014, 2015						
	Humana Health Plan	2014, 2015	X	X				
	Kaiser Permanente	2014, 2015					X	X
	Rocky Mountain Health Plans	2014, 2015						
Connecticut	Anthem BlueCross and BlueShield of Connecticut (PPO)	2014, 2015	X	X				
	Anthem BlueCross and BlueShield of Connecticut (HMO)	2015	X	X				
	Anthem BlueCross and BlueShield of Connecticut (PPO, multistate)	2015	X	X				
	Anthem BlueCross and BlueShield of Connecticut (HMO, multistate)	2015	X	X				
	ConnectiCare	2014, 2015						
	UnitedHealthcare	2015				X		
	Healthy CT	2014, 2015	X					
	Healthy CT (multistate)	2015	X					

State	Insurer	Year	Exclusion					
			Treatment of conditions resulting from noncovered services	Maintenance therapy	Genetic testing	Fetal reduction surgery	Treatment of self-inflicted conditions	Preventive services not required by law
Florida	Assurant Health	2015	X		X			X
	Humana Medical Plan	2015	X	X	X			X
	Molina Healthcare	2015						
	Preferred Medical Plan	2015	X				X	
Maine	Anthem BlueCross BlueShield	2014, 2015	X	X	X	X		
	Anthem BlueCross BlueShield (multistate)	2014, 2015	X	X	X	X		
	Harvard Pilgrim	2015						
	Maine Community Health Options	2014, 2015		X				
Maryland	All Savers, UnitedHealthcare	2014						X
	CareFirst Blue Choice	2014						
	CareFirst BlueCross BlueShield	2014						
	CareFirst BlueCross BlueShield (multistate)	2014						
	Evergreen Health Cooperative	2014						
	Group Hospitalization, Medical Services/CareFirst BlueCross BlueShield	2014						
	Kaiser Permanente	2014						
Minnesota	BlueCross BlueShield of Minnesota	2014						
	HealthPartners	2014						
	Medica	2014	X					
	PreferredOne	2014						
	Ucare	2014						
Nevada	Anthem BlueCross Blue Shield	2014, 2015	X	X	X	X		
	Anthem BlueCross Blue Shield (multistate)	2014, 2015	X	X	X	X		
	Nevada Health CO-OP	2014, 2015	X					
	Prominence HealthFirst	2015	X				X	
	Saint Mary's Health First	2014	X				X	
	Time Insurance Co.	2015	X					X
	Health Plan of NV, UnitedHealthcare	2014, 2015	X				X	

State	Insurer	Year	Exclusion					
			Treatment of conditions resulting from noncovered services	Maintenance therapy	Genetic testing	Fetal reduction surgery	Treatment of self-inflicted conditions	Preventive services not required by law
Ohio	Aetna	2015		X	X			
	Anthem BlueCross Blue Shield/ Community Health	2014, 2015		X		X	X	
	AultCare	2014, 2015						
	Buckeye Community Health	2014				X		
	CareSource	2014, 2015		X				
	Coordinated Health Mutual	2015		X				
	Coventry Health America One	2014	X	X				
	HealthSpan	2014, 2015						
	Humana	2014			X		X	X
	Kaiser	2014						
	Medical Health Insuring	2014, 2015						
	Molina	2014, 2015		X				
	Paramount	2014, 2015	X	X				
	Premier Health Plan	2015						
	Summa	2014, 2015	X					
	Time Insurance Co.	2015	X		X			X
	United Healthcare of Ohio	2015				X		
Rhode Island	BlueCross BlueShield of RI	2014, 2015						
	Neighborhood Health Plan	2014, 2015						
South Carolina	BlueCross BlueShield Blue Essentials	2015	X		X		X	
	BlueChoice Health Plan	2015	X		X			
	BlueCross BlueShield (multistate)	2015	X		X		X	
	Consumers Choice	2015		X				
	Coventry HMO	2015	X					
	Coventry POS	2015	X					
	Time Insurance Co./Assurant Health	2015	X		X			X
South Dakota	Sanford Health Plan	2014	X		X		X	X
Tennessee	BlueCross BlueShield of TN	2014		X				
	CIGNA	2014		X				
	Community Health Alliance	2014		X				
	Humana	2014	X	X	X		X	X
Washington	BridgeSpan Health Co.	2014, 2015	X					
	Community Health Plan	2014, 2015	X					
	Coordinated Care	2014, 2015	X			X		
	Kaiser	2014						
	LifeWise Health Plan	2014, 2015						
	Moda Health Plan	2015	X					
	Molina Healthcare	2014, 2015						
	Premera Blue Cross	2014						
	Premera Blue Cross Multi-State Plan	2014						

State	Insurer	Year	Exclusion					
			Treatment of conditions resulting from noncovered services	Maintenance therapy	Genetic testing	Fetal reduction surgery	Treatment of self-inflicted conditions	Preventive services not required by law
Wisconsin	Anthem BlueCross BlueShield	2014	X	X		X		
	Anthem BlueCross BlueShield (multistate)	2014	X	X		X		
	Arise Health Plan	2014	X					
	Common Ground CO-OP	2014		X				
	Dean Health Plan	2014	X					
	Gunderson Health Plan	2014						
	Health Tradition Health Plan	2014	X					
	Medica	2014	X					
	Molina Healthcare	2014						
	Physicians Plus	2014						
	Prevea 360 Health plan	2014	X	X				
	Security Health Plan	2014	X					

Notes

[1] L. Codispoti, B. Courtot, J. Swedish et al., *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (National Women's Law Center, 2008); C. Turner, *Rape Is Not a Pre-Existing Condition* (National Women's Law Center, Oct. 22, 2009).

[2] D. Garret, *Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act* (National Women's Law Center, 2012).

[3] B. Courtot and J. Kaye, *Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition* (National Women's Law Center, 2009). Only 13% of individual market plans available to a 30-year-old woman in 2009 provided maternity coverage.

[4] See, e.g., R. Robertson, D. Squires, T. Garber, S. R. Collins, and M. M. Doty, *Oceans Apart: The Higher Health Costs of Women in the U.S. Compared to Other Nations, and How Reform Is Helping* (The Commonwealth Fund, July 2012); and S. Rustgi, M. M. Doty, and S. R. Collins, *Women at Risk: Why Many Women Are Forgoing Needed Health Care* (The Commonwealth Fund, May 2009).

[5] P. Johnson, T. Fitzgerald, A. Salganicoff et al., *Sex-Specific Medical Research: Why Women's Health Can't Wait* (Mary Horrigan Connors Center for Women's Health & Gender Biology at Brigham and Women's Hospital, 2014).

[6] See 45 C.F.R. Part 156. While the ACA explicitly requires that QHPs cover habilitative services, which help an enrollee keep, learn, or improve skills and functioning for daily living, there is no parallel requirement to cover other medical services specifically meant to maintain or keep a specific level of health.

[7] "Women were more likely than men to report multiple chronic conditions," J. Gerteis, D. Izrael, D. Deitz et al., *Multiple Chronic Conditions Chartbook: 2010 Medical Expenditure Panel Survey Data* (Agency for Healthcare Research and Quality, April 2014). "Women consistently report a higher prevalence of chronic pain than men . . . and are at greater risk for many pain conditions," Institute of Medicine, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* (National Academies Press, 2011). "Females had higher rates of depression than males in every age group," L. Pratt and D. Brody, *Depression in the U.S. Household Population, 2009–2012,* NCHS Data Brief, No. 172 (National Center for Health Statistics, Dec. 2014). "More than 90 percent of people with lupus are women between the ages of 15 and 45," Office on Women's Health, "Lupus Fact Sheet" (U.S. Department of Health and Human Services, July 16, 2012).

[8] "In many cases, there is no cure for chronic pain. Therefore, treatment goals and clinical focus include pharmacologic and non-pharmacologic methods to improve the management of pain, improve quality of life, and decrease suffering," American Academy of Pain Medicine, "Use of Opioids for the Treatment of Chronic Pain" (American Academy of Pain Medicine, Feb. 2013). Recommendations and guidelines for maintenance therapy for depression: American Psychiatric Association, *Practice Guideline for the Treatment of Patients with Major Depressive Disorder,* 3rd ed. (American Psychiatric Association, 2010). Recommendations and guidelines for maintenance treatment for lupus nephritis: B. H. Hahn, M. A. McMahon, A. Wilkinson et al., "American College of Rheumatology Guidelines for Screening, Treatment, and Management of Lupus Nephritis," *Arthritis Care & Research,* June 2012, 64(6):797–808.

[9] A health insurance company that excludes coverage for maintenance therapy in QHPs in five states has a medical policy that describes an expensive medication often used for treatment for terminal lung cancers as "medically necessary" and "maintenance therapy." Anthem, "Bevacizumab (Avastin®) for Non-Ophthalmologic Indications," Medical Policy (Nov. 2015); see also National Cancer Institute, "Maintenance Therapy," NCI Dictionary of Cancer Terms (National Institutes of Health).

[10] Cancer Prevention and Control, "Cancer Among Women" (Centers for Disease Control and Prevention, June 16, 2016).

[11] Marketplace plans must cover screening for harmful mutations related to the BRCA1 and BRCA2 genes for women with a family history of certain cancers, because such screening receives a B grade from the United States Preventive Services Task Force. See http://www.cancer.gov/types/breast/hp/breast-ovarian-genetics-pdq.

[12] American Congress of Obstetricians and Gynecologists, "Identification and Referral of Maternal Genetic Conditions in Pregnancy," Committee Opinion (Oct. 2015); American Congress of Obstetricians and Gynecologists, "Screening for Tay-Sachs Disease," Committee Opinion (Oct. 2005, reaffirmed 2014).

[13] American Congress of Obstetricians and Gynecologists, "Prenatal Diagnostic Testing for Genetic Disorders," Practice Bulletin (May 2016); and American Congress of Obstetricians and Gynecologists, "Screening for Fetal Anauploidy," Practice Bulletin (May 2016).

[14] B. Luke and M. B. Brown, "Contemporary Risks of Maternal Morbidity and Adverse Outcomes with Increasing Maternal Age and Plurality," *Fertility and Sterility,* Aug. 2007 88(2):283–93.

[15] Ibid.

[16] Community Health Plan of Washington, "2015 Community HealthEssentials Plus," in Health Care Coverage Agreement for Individuals and Families (Community Health Plan, 2015).

[17] Unpublished National Women's Law Center analysis of data from Injury Prevention & Control: Data & Statistics (WISQARSTM), "Nonfatal Injury Reports, 2001–2013" (Centers for Disease Control and Prevention, 2010–2013). Between 2010 and 2013 women ages 18–65 were 22.6% more likely to have a nonfatal injury from self-harm, including suicide attempts and other self-harm, than were men in the same age range.

[18] See 45 C.F.R. Part 156. The EHB requires that QHPs provide mental health coverage in parity with other health services, but there is a lack of clarity on how this applies if an individual has not been diagnosed with a condition, or if the issuer excludes all self-inflicted injuries or conditions, regardless of physical or mental health diagnoses.

[19] D. Brauser, "Postpartum Depression Underidentified, Undertreated," *Medscape,* March 21, 2013; S. Thurgood, D. M. Avery, and L. Williamson, "Postpartum Depression (PPD)," *American Journal of Clinical Medicine,* Spring 2009 6(2):17–22. Postpartum depression is undiagnosed more often than many other health conditions because many providers do not screen for it, and because of social stigma that prevents mothers from reporting symptoms.

[20] National Comprehensive Cancer Network, "Breast Cancer Risk Reduction," in NCCN Guidelines Version 2 2015 (NCCN, 2015). Evidence-based, consensus guidelines recommend these procedures to reduce cancer risk for women with these genetic mutations and for women with a compelling family history or a history of radiation therapy to the chest early in life.

[21] Centers for Disease Control and Prevention, "Sexual Assault and Abuse and STDs," in 2015 Sexually Transmitted Diseases Treatment Guidelines (CDC, 2015). Many women need access to prophylactic antiretroviral medications. Excluding such services raises a particular concern for survivors of sexual assault who may not know if they were exposed to STDs.

[22] American Cancer Society, "American Cancer Society Recommendations for Early Breast Cancer Detection in Women Without Breast Symptoms," in Breast Cancer and Early Detection (Oct. 20, 2015). Providers may recommend an MRI for women with higher than average risk for breast cancer, but MRIs are not included in the ACA's required preventive services.

[23] See, e.g., C. M. Puskas, J. I. Forrest, S. Parashar et al., "Women and Vulnerability to HAART Non-Adherence: A Literature Review of Treatment Adherence by Gender from 2000 to 2011," *Current HIV/AIDS Reports,* Dec. 2011 8(4):277–87; M. Manteuffel, S. Williams, W. Chen et al., "Influence of Patient Sex and Gender on Medication Use, Adherence, and Prescribing Alignment with Guidelines," *Journal of Women's Health,* Feb. 2014 23(2):112–19.

[24] See, e.g., these statements on H.R. 4872. Representative Barbara Lee: "While health care reform is essential for everyone, women are in particularly dire need for major changes to our health care system. Too many women are locked out of the health care system because they face discriminatory insurance practices and cannot afford the necessary care for themselves and for their children," 111 Cong. Rec. 156, H1632 (March 18, 2010). Representative Nancy Pelosi: "It's personal for women. After we pass this bill, being a woman will no longer be a preexisting medical condition," 111 Cong. Rec. 156, H1896 (March 21, 2010). Senator Barbara Boxer: "Women have even more at stake. Why? Because they are discriminated against by insurance companies, and that must stop, and it will stop when we pass insurance reform," 111 Cong. Rec. 155, S10263 (Oct. 8, 2009). Senator Barbara Mikulski: "Health care is a women's issue, health care reform is a must-do women's issue, and health insurance reform is a must-change women's issue because . . . when it comes to health insurance, we women pay more and get less," 111 Cong. Rec., S10265 (Oct. 8, 2009).

[25] 45 C.F.R. Part 156.

[26] 45 C.F.R. Part 156.

[27] J. Giovannelli, K. Lucia, and S. Corlette, *Implementing the Affordable Care Act: Revisiting the ACA's Essential Health Benefits Requirements* (The Commonwealth Fund, Oct. 2014). Only nine states and the District of Columbia ban substitutions.

[28] 42 U.S. Code § 300gg–15.

[29] 45 C.F.R. Part 147.

About This Study

The authors analyzed plan documents from 109 insurers offering qualified health plans in 16 states for 2014, 2015, or both years. They identified language regarding excluded health services (exclusions) that leave gaps in coverage for women's health care needs. This brief builds on a prior analysis of plan language that explicitly violates key requirements of the ACA, such as charging cost-sharing for preventive services.[i]

The analysis includes exclusions that could be used in a manner prohibited under the law, for example, as a subterfuge for a preexisting condition exclusion or as a means of discriminating against women with chronic conditions.[ii] The analysis does not indicate whether medical claims were approved or denied but rather highlights the potential for denial under the plan language.

For most states, the analysis covers one plan year; for eight states, the authors looked at plans from both 2014 and 2015.[iii] Insurers are counted separately for each state and for each product type (i.e., HMO or PPO). In addition, multistate plans are listed separately from other products offered by the same insurer in a state. Insurers whose plan documents for both 2014 and 2015 were reviewed appear only once. Note that insurers may no longer offer some plans, or they may have changed plan language.

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[i] See National Women's Law Center, *State of Women's Coverage: Health Plan Violations of the Affordable Care Act* (NWLC, 2015). Previous analysis by the National Women's Law Center found violations of the ACA by at least one insurer in every state included in the analysis, across a wide range of women's health concerns.

[ii] See 45 C.F.R. Part 107.

[iii] See Exhibit 2 and Exhibit 3 listing all plans reviewed and the category of exclusions in each plan. State plans reviewed for both years: California, Colorado, Connecticut, Maine, Nevada, Ohio, Rhode Island, and Washington. State plans reviewed only for 2014: Maryland, Minnesota, South Dakota, Tennessee, and Wisconsin. State plans reviewed only for 2015: Alabama, Florida, and South Carolina.

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