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Realizing Health Reform's Potential: *Women and the Affordable Care Act of 2010*

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Abstract: This issue brief analyzes how, over the next decade, the Affordable Care Act (ACA) is likely to stabilize and reverse women's growing exposure to health care costs. Up to 15 million women who now are uninsured could gain subsidized coverage under the law. In addition, 14.5 million insured women will benefit from provisions that improve coverage or reduce premiums. Women who have coverage through the individual insurance market and are charged higher premiums than men, who have been unable to secure coverage for the cost of pregnancy, or who have a preexisting health condition excluded from their benefits will ultimately find themselves on a level playing field with men, enjoying a full range of comprehensive benefits.



Overview

Women, on average, have far more contact with the health care system over their lifetimes than men do. The health care needs of women are greater, especially during their reproductive years, and historically women have played a central role in coordinating health care for family members, from spouses and children to aging parents.¹ While women are equally as likely as men to be without health insurance, their own unique health care needs leave them more exposed to the rapidly rising costs of care and to the problems resulting from loss of health coverage.²

Because insurance carriers consider women, particularly young women, a higher risk than men, women experience more difficulty obtaining coverage from the individual market and are charged much higher premiums for the same benefits than men of the same age.³ Most policies sold in the individual market, moreover, will not cover the costs of a pregnancy. Women's higher health care costs mean that they are more likely than men to experience problems paying medical bills—their own and those of family members.⁴ And women, both insured and uninsured, are more likely than men to delay health care to avoid the associated costs.

This issue brief analyzes how the new health care reform law, the Affordable Care Act (ACA), will, over the next decade, stabilize and reverse women's growing exposure to health care costs.⁵ While women and their families

will realize the greatest benefits from the expansion and improvement of insurance coverage beginning in 2014, several ACA provisions that are to be implemented during 2010—or have already been implemented—will provide important transitional support (Exhibit 1). The provisions that will benefit women, and their expected impact, are summarized below.

Summary of Health Reform Law Provisions Benefiting Women

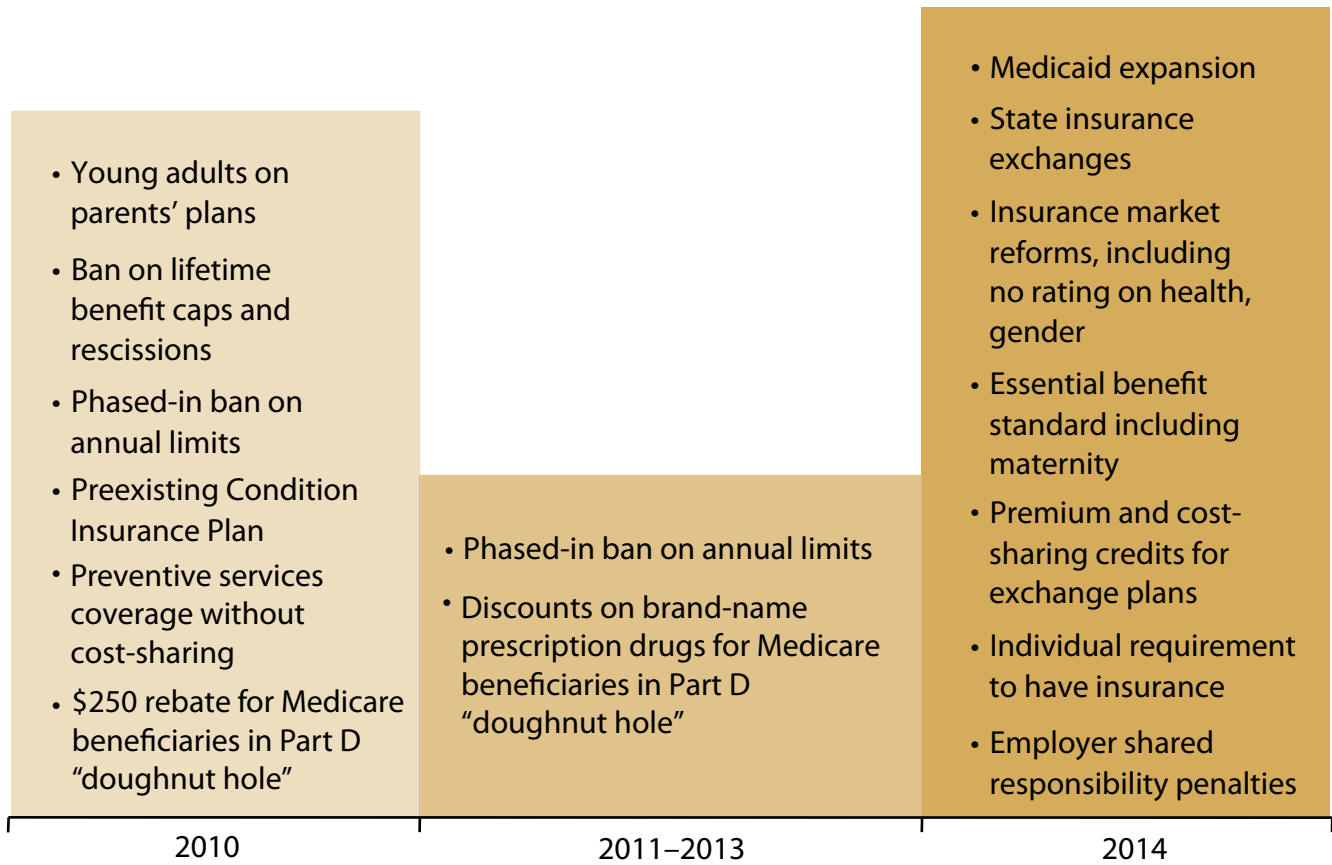
2010–2013

- *Requirement that employers and insurers allow adult children up to age 26 to join or remain on a parent's health plan (Sept. 2010).* Nearly 1 million uninsured adult children are expected to gain coverage through their parents' policies over the next three years, while another 600,000 currently enrolled in individual market plans will gain more-affordable coverage by joining their parents' plans.
- *Ban on lifetime coverage limits (Sept. 2010).* About 102 million people have health plans with lifetime benefit limits, and each year up to 20,400 people exceed their plan limits and lose coverage. Assuming that women make up half the population, about 10,000 women would gain coverage as a result of the ban.
- *Phased-in restrictions on annual benefit limits (Sept. 2010).* An estimated 18 million people have health plans with annual benefit limits. The Affordable Care Act increases the cap on annual limits over 2010–2013, before banning them completely in 2014. By 2013, up to 3,500 people will gain coverage as a result of the ban, about 1,750 of them women.
- *Bans on rescissions of coverage (Sept. 2010).* About 15 million people who have coverage through the individual insurance market, where rescissions, or cancellations, of health policies are most common, will benefit from this ban. About 10,700 people, including 5,350 women, are estimated to have their coverage rescinded each year.
- *Preexisting condition insurance plans (July–Aug. 2010).* An estimated 200,000 people, including approximately 100,000 women, who have serious health problems and have had difficulty obtaining insurance coverage will gain coverage through these plans over the next three years.
- *Rebates to Medicare beneficiaries in the drug coverage doughnut hole (2010).* Each year, about 16 percent of Medicare beneficiaries—a disproportionate number of them women—will hit the “doughnut hole” in their prescription drug coverage. Starting this year, beneficiaries will receive \$250 rebates when they reach the hole, which will be phased out completely by 2020.

2014 and Beyond

- *Expansion in Medicaid eligibility to cover adults with incomes below 133 percent of the federal poverty level (Jan. 2014).* The expansion in Medicaid has the potential to cover up to 8.2 million uninsured adult women under age 65 (Exhibit 2).
- *New state health insurance exchanges, with premium and cost-sharing subsidies for people with low and moderate incomes (Jan. 2014).* Up to 7 million uninsured adult women under age 65 may gain subsidized coverage through the exchanges (Exhibit 2).
- *Essential health benefit standards that include maternity care, as well as limits on cost-sharing, for plans sold in insurance exchanges and in the individual and small-group markets (Jan. 2014).* This provision will ensure that all women have health plans that cover the cost of a pregnancy, a major gap in the individual insurance market, where only 13 percent of health plans now include maternity benefits.⁶ The new benefit standard and out-of-pocket spending limits also promise to significantly reduce the estimated 14.5

Exhibit 1. Affordable Care Act Implementation Timeline: Provisions Benefitting Women



Source: Commonwealth Fund analysis of the Patient Protection and Affordable Care Act (Public Law 111–148 and 111–152).

million women who are considered underinsured because of their high out-of-pocket costs relative to income.⁷

- *Prohibitions on insurance carriers from denying coverage or charging higher premiums on the basis of health or gender (Jan. 2014).* An estimated 7.3 million women—38 percent—who tried to buy health insurance in the individual market over a recent three-year period were turned down, charged a higher premium, or had a condition excluded from coverage because it was preexisting (Exhibit 3).⁸ Moreover, rating on the basis of gender is currently permitted in the individual market in 42 states, while 38 states allow insurance carriers to take into account gender in pricing health insurance policies for small businesses, a blow to women in companies with predominantly female workforces. Millions of

women will benefit from the new rules prohibiting denial of coverage or higher premiums based on health or gender.

Health Reform: How Women and Their Families Will Benefit, 2010–2013

The provisions of the Affordable Care Act that will go into effect earliest are designed to provide the uninsured and people with inadequate coverage purchased in the individual insurance market with transitional relief while the law's major reforms are being implemented prior to launch in 2014. Many of these early provisions will particularly benefit women. Initial projections from the Congressional Budget Office (CBO) and the Departments of Health and Human Services (HHS), Labor, and Treasury show that about 1 million people will gain coverage as a result of provisions

taking effect over the period 2010–2013. Millions more will see the quality of their coverage improve, including more than 100 million people who currently have lifetime or annual limits on their health benefits and 15 million people with individual market insurance who face possible rescission of their coverage were they to become sick.

Ability of Young Adults to Join or Stay on a Parent’s Plan Until Age 26 (2010)

High school and college graduation are major life transitions for children and their parents for many reasons, not the least of which is that new graduates face losing their health insurance coverage when they are no longer eligible to stay on their parents’ employer plan or no longer eligible for public coverage through Medicaid or the Children’s Health Insurance Program.⁹ Nearly 9 million young adults between the ages of 19 and 25 lacked health insurance in 2008, accounting for 19 percent of the 45.7 million uninsured people under age 65.¹⁰

As of September 23, 2010, the ACA requires all insurance plans that offer dependent coverage to ensure the same level of coverage, at the same price, to their enrollees’ adult children up to their 26th birthday.¹¹ The law applies to all adult children, regardless of living situation, degree of financial independence, or marital or student status. Health plans or employers cannot charge adult children a higher premium or offer fewer benefits than they do for young children. In addition, the employer premium contribution is tax-exempt, no matter the child’s age or dependent status.

The law applies to all forms of health insurance, including that offered through employers, whether they are self-insured (i.e., they pay benefits directly to employees) or fully insured (i.e., they purchase health benefits for employees from an insurance company). It also applies to insurance plans that parents purchase through the individual insurance market. The law also applies to new health plans and so-called “grandfathered” health plans—those that were in existence when the ACA was signed into law in March 2010.¹² There is one restriction: prior to 2014, young adults may be covered by their parents’ grandfathered

employer group health plans only if they are not eligible to enroll in any other employer-sponsored plan (i.e., through their own employer or a spouse’s employer).

How soon will young adults start to benefit from the new provision? Health plans and employers that offer dependent coverage are required on or after September 23, 2010, to hold an enrollment period during which young adults join their parents’ plans. Plans and employers can, however, use their normal annual enrollment period to satisfy the requirement. While a few firms and insurers have already made changes to allow young adults who might have lost coverage at graduation this year to stay on their parent’s plans, many have announced that they will wait for their normal enrollment period to fulfill the requirement. A survey of 800 large employers by Mercer found that 16 percent would implement the new law ahead of September 23, but 75 percent said they planned to use their annual enrollment period to sign up newly eligible young adults.¹³

In their interim final regulations, the Departments of Health and Human Services, Labor, and Treasury estimate that about 1.2 million young adults will become covered under their parents’ policies in 2011.¹⁴ Of those, about 650,000 will have been previously uninsured and 550,000 will have purchased coverage in the individual insurance market.

Prohibitions on Lifetime Benefit Limits and Restrictions on Annual Limits (2010)

More than 100 million people in the United States are enrolled in health plans that limit how much they will pay out to an enrollee who becomes very sick.¹⁵ While the majority of people who have such limits on their policies will not exceed them, benefit limits can create enormous anxiety for women when they or a family member become seriously ill or injured, particularly when the limits are set low.

About 102 million people have health insurance policies, either through their employers and or through the individual market, that feature limits on what their plans will pay over a lifetime. About 63 percent of large firms, 52 percent of small firms, and nearly 90 percent

Exhibit 2. Distribution of 16.8 Million Uninsured Women by Federal Poverty Level and Provisions of the Affordable Care Act

Uninsured women ages 19–64 in 2008

Federal Poverty Level	Percent	Number Uninsured	Premium Cap as a Share of Income	Cost-Sharing Cap (Share of Enrollee's Health Costs)
<133% FPL	49%	8,237,639	Medicaid	Medicaid
133%–149% FPL	6%	1,025,277	3.0%–4.0%	6%
150%–199% FPL	13%	2,158,344	4.0%–6.3%	13%
200%–249% FPL	9%	1,571,793	6.3%–8.05%	27%
250%–299% FPL	6%	1,007,372	8.05%–9.5%	30%
300%–399% FPL	7%	1,205,784	9.5%	30%
Subtotal (133%–399% FPL)	41%	6,968,570	3.0%–9.5%	6%–30%
>400% FPL	10%	1,641,979	—	—
Total	100%	16,848,188	—	—

Source: Analysis of the March 2009 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund; Commonwealth Fund analysis of the Patient Protection and Affordable Care Act (Public Law 111–148 and 111–152).

of health plans sold in the individual market impose lifetime limits on benefits.¹⁶ Nearly three-quarters (74%) of plans have a lifetime limit of \$2 million or more, one-quarter have a limit of \$1 million to \$2 million, and less than 2 percent have a limit under \$1 million. Of the people enrolled in these plans, each year an estimated 18,650 to 20,400 exceed their limit and thus lose their coverage.

Far fewer health plans impose annual limits on their benefits. About 18 million people have policies that place limits on what their plans will pay out on an annual basis.¹⁷ An estimated 8 percent of large firms, 14 percent of small firms, and 19 percent of individual market plans impose annual limits. Each year up to 3,500 people exceed their limit.

Lifetime limit ban. Starting on September 23, 2010, the ACA prohibits all health plans from imposing lifetime limits on what their plans will pay in benefits.¹⁸ The ban applies to all employer plans, including self-insured plans, and all plans sold in the individual insurance market. It also applies to new plans and grandfathered plans. For people who exceed their lifetime limit before September 23, health plans must serve notice that the lifetime limit no longer applies

and provide an enrollment period for people who since disenrolled from the plan.

Phased-in restrictions on annual limits. The ACA will prohibit all health plans, except grandfathered plans sold on the individual market, from imposing annual limits in 2014, but places restrictions on annual limits that increase gradually between 2010 and 2013, according to the following schedule:

- Between September 23, 2010, and September 23, 2011, plans cannot impose annual limits on health benefits of less than \$750,000.
- Between September 23, 2011, and September 23, 2012, plans cannot impose annual limits of less than \$1.25 million.
- Between September 23, 2012, and January 1, 2014, plans cannot impose annual limits of less than \$2 million.

The restrictions on annual limits apply to “essential health benefits” as they are broadly defined in the ACA and not benefits that fall outside that definition (see “[Essential Health Benefit Standards, Including Maternity Coverage](#),” below). While the

Exhibit 3. Nearly Two of Five Women Who Have or Tried to Buy Individual Insurance Were Turned Down, Charged a Higher Price, or Had A Preexisting Condition Excluded From Coverage
Adults ages 19–64

	Total	Women	Men	Women			
				<\$40,000/ year	\$40,000+/ year	Health problem	No health problem
<i>Adults with individual coverage or who tried to buy it in past three years who:</i>							
Found it very difficult or impossible to find coverage they needed	47%	51%	42%	56%	41%	58%	43%
Found it very difficult or impossible to find affordable coverage	57	62	51	69	52	77	48
Were turned down, charged a higher price, or had a preexisting condition excluded from coverage	36	38	34	42	36	45	31
Never bought a plan	73	74	72	84	55	79	68

Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

HHS secretary is required to determine the benefit package through future regulations, health plans must make good-faith efforts to comply with the annual limit restrictions on essential benefits as they are now defined in the ACA.

Prohibitions on Rescissions of Coverage (2010)

Insurance companies selling in the individual market often investigate the medical records of enrollees who become sick to determine whether there is any cause to cancel, or rescind, their policies. A rescission is retroactive in nature, in that it cancels benefits dating back to the time of enrollment in a health plan. A 2009 investigation by the House Energy and Commerce Committee found that some insurance companies automatically initiate investigations into the health histories of enrollees who develop particular illnesses or conditions, such as cancers, asthma, or rheumatoid arthritis, by use of extensive lists of diagnosis codes.¹⁹ The investigation found that between 2003 and 2007, three insurance companies rescinded nearly 20,000 insurance policies. In an example of one such case, a Texas woman who was diagnosed with breast cancer

in 2006 had her insurance policy rescinded when her carrier discovered that she had failed to disclose that she had been previously diagnosed with osteoporosis and bone density loss. The HHS, Labor, and Treasury Departments estimate that about 10,700 people per year have their coverage rescinded.²⁰

Starting on September 23, 2010, all health insurance plans are prohibited from rescinding coverage once an enrollee is covered under a plan, except in the case of an individual who has performed an act or practice that constitutes fraud or who makes an intentional misrepresentation of material fact. The ban applies to all employer plans, including self-insured plans, and all plans sold on the individual insurance market. It also applies to both new plans and grandfathered plans. In the case of rescissions that are permissible under the new rules, health plans must provide at least 30 days' notice to enrollees prior to policy cancellation.

The ban on rescissions will primarily benefit the estimated 15 million people who currently have health insurance through the individual market, since few employer group plans ever rescind policies.

Preexisting Condition Insurance Plan (2010)

Women will also benefit from a provision in the ACA that will provide temporary relief to adults with pre-existing health conditions who are uninsured during the period 2010–2013. The new Preexisting Condition Insurance Plan (PCIP), to be available in most states by the end of this summer, will help some women themselves gain coverage, but will also provide some relief for women who are caring for partners or parents who are ailing and uninsured.²²

People who have been uninsured for at least six months and who have a health problem will be eligible to purchase a PCIP in their state. Premiums will be set for a standard population in the individual insurance market and cannot vary by more than a factor of four, based on age (i.e., 4:1 age bands). The PCIPs will be required to cover, on average, no less than 65 percent of medical costs (actuarial value) and to limit out-of-pocket spending to that which is defined for health savings accounts (HSAs), or \$5,950 for individual policies and \$11,900 for family policies. They also cannot impose preexisting condition exclusions.

The federal government invited states to submit applications to form their own PCIPs, supported by federal subsidies to cover the difference between premiums and the cost of claims. To date, 29 states and the District of Columbia have applied to run their own plans.²³ Of those, 18 states began enrollment in July and the remainder will start enrollment in August. States have some flexibility in setting the size of the deductible, the level of other cost-sharing, and the scope of benefits, so there will be variation in PCIPs from state to state.

In the 21 states that have not submitted applications, the federal government began operation of the PCIPs on July 1 through the nonprofit Government Employees Health Association (GEHA)—the second-largest national insurance plan providing coverage to federal workers through the Federal Employees Health Benefit Program (FEHBP).²⁴ These self-insured plans, which will be the same in all 21 states (although premiums will vary) will feature a \$2,500 deductible, 20 percent coinsurance, no cost-sharing for preventive

services, no lifetime limit on benefits, and a \$5,950 out-of-pocket maximum for in-network services.

The HHS secretary will have \$5 billion to use to subsidize the gap between premiums collected for the PCIPs and claims costs between 2010 and 2013. The CBO estimates that the PCIPs will be able to cover about 200,000 people over their three-and-half years of operation.²⁵

Preventive Care: Required Coverage and Prohibitions on Cost-Sharing (2010)

Women and their families who do not now have full coverage of preventive care services like mammography and childhood immunizations will benefit from new requirements that health plans both cover recommended preventive services and that they not impose cost-sharing requirements on those services. The requirements apply to both group and individual market plans, but they do not apply to grandfathered plans in any market.²⁶

Beginning on September 23, 2010, all non-grandfathered health plans will be required to cover the following services without cost-sharing:²⁷

- Recommended services that receive an ‘A’ or ‘B’ rating from the U.S. Preventive Services Task Force. Those services that particularly benefit women include:
 - breast cancer screening every one to two years for women age 40 and older;
 - cervical cancer screening;
 - sexually transmitted infection screening;
 - genetic counseling and testing for the breast cancer (BRCA) gene;
 - osteoporosis screening for all women 65 and older, and 60 and older for those at high risk;
 - colorectal cancer screening;
 - blood pressure and cholesterol screening;
 - aspirin to prevent cardiovascular disease in women ages 55 to 79; and
 - depression screening for adolescents and adults.

- Immunizations for children, adolescents, and adults that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- Preventive care and screenings for infants, children, and adolescents recommended by the Health Resources and Services Administration (HRSA); and
- Preventive care and screenings for women. Guidelines for these services will be released by HHS by August 1, 2011.

The ACA also includes a special provision directed at raising awareness of, and increasing screening for, breast cancer in young women, with the HHS secretary required to establish educational campaigns targeting health care professionals and the general public. In addition, the secretary is required to pursue prevention research activities, through the CDC and the National Institutes of Health (NIH), on breast cancer in younger women. Grants will also be awarded to organizations that provide support for young women diagnosed with breast cancer.

Rebates to Medicare Beneficiaries in the Drug Coverage “Doughnut Hole”; Start of Doughnut Hole Phase-Out (2010)

The Medicare prescription drug benefit (Part D) covers the cost of beneficiaries’ medications up until they reach a coverage gap—the notorious “doughnut hole”—at which point beneficiaries must pay the full cost of their prescriptions. Under the standard Medicare Part D benefit, the coverage gap starts when the retail cost of a beneficiary’s medications reaches \$2,830 and continues until the beneficiary has spent \$4,550 out-of-pocket.²⁸ A recent study found that about 16 percent of Medicare beneficiaries reach the doughnut hole each year.²⁹ Women, in addition to people with diabetes and Alzheimer’s disease, are the most

likely to end up in the doughnut hole. Beneficiaries with end-stage renal disease, coronary artery disease, chronic obstructive pulmonary disease, mental health conditions, and congestive heart failure are also among the most likely to reach the doughnut hole.

This year, Medicare beneficiaries who reach the doughnut hole will automatically receive a \$250 rebate from the Medicare program. This marks the beginning of the gradual phase-out of the coverage gap over the next decade. In 2011, Medicare beneficiaries in the doughnut hole will receive 50 percent discounts on all brand-name drugs. Additional discounts on brand-name drugs and generic drugs will be phased in over ensuing years, such that the doughnut hole is closed completely by 2020. Because women are most likely to reach the doughnut hole, they will be among the primary beneficiaries of the rebates and gradual phase-out.

The ACA: How Women and Their Families Will Benefit, 2014 and Beyond

The most sweeping health insurance reforms included in the Affordable Care Act will be implemented in 2014. Nearly 17 million working-age women ages 19 to 64 were without health insurance in 2008—about 18 percent of all women in that age group. Nearly all uninsured women who are legal residents will eventually gain coverage under the new reform law. Women will also benefit from gains in health insurance coverage and the associated improvements in access to care and coverage of medical expenses resulting from their children, spouses, and parents gaining insurance.

There will be particularly large gains for women living in states where their risk of being uninsured is greater. These states include New Mexico and Texas, where 29 percent of working-age women were uninsured in 2008; Florida and Louisiana, where 24 percent were uninsured; Alaska, Arizona, Arkansas, California, Georgia, Mississippi, and West Virginia, where 21 to 22 percent were uninsured; and Idaho, Kentucky, Nevada, and Oklahoma, where 20 percent were uninsured.³⁰

Expanding Medicaid Coverage for Adults up to 133 Percent of Poverty (2014)

Beginning in 2014, the ACA expands eligibility for Medicaid for all legal residents up to 133 percent of the federal poverty level, about \$14,404 for a single adult or \$29,327 for a family of four. This is a substantial change in Medicaid's coverage of adults. Although several states have expanded eligibility for parents of dependent children, in most states income eligibility thresholds are well below the federal poverty level. And adults who do not have children are currently not eligible for Medicaid, regardless of income, in most states.

Because half (49%) of women who are uninsured live in households with incomes under 133 percent of poverty, this provision will potentially have the greatest effect on increasing health insurance among women (Exhibit 3). The eligibility expansion has the potential to provide health coverage to up to 8.2 million uninsured women ages 19 to 64 in that income range.³¹

Prohibitions Against Denying Coverage or Charging Higher Premiums Based on Health Status or Gender (2014)

Millions of women will benefit from new insurance market reforms that neutralize the effects of health and gender on their ability to buy health insurance. An estimated 7.3 million women, or 38 percent, who tried to buy health insurance in the individual market over a recent three-year period were turned down, charged a higher premium, or had their condition excluded from their health plan because of a preexisting health condition (Exhibit 3).³² Currently, rating on the basis of gender is permitted in the individual market in 42 states, with some plans charging as much as 84 percent more for women than men in the same age group for the same insurance policy.³³ Thirty-eight states also allow insurance carriers to price policies for small businesses on the basis of gender as well, which means that companies that have predominantly female workforces may be charged higher premiums than male-dominated companies.

Beginning in January 2014, all insurance carriers are required to accept every individual who applies for coverage (guaranteed issue and renewability), and are prohibited from charging higher premiums on the basis of health status or gender. Premiums can reflect age (but cannot vary by more than a ratio of 3:1), tobacco use, family composition, participation in a health promotion program, and geography.

Essential Health Benefit Standards, Including Maternity Coverage (2014)

In an analysis of health insurance plans sold in the individual market, the National Women's Law Center found that just 13 percent of the plans studied included maternity benefits, though there was substantial variation across states.³⁴ All health plans in Massachusetts, New Jersey, and Oregon included maternity benefits, but in 22 states, no plan covered costs related to pregnancy. Other studies have shown that when individual market plans do include maternity benefits, they often severely limit the amount of costs covered or have long waiting periods before coverage begins.³⁵

Starting in 2014, all health plans sold through the new state insurance exchanges (see below) as well as the individual and small-group markets will be required to include coverage of maternity and newborn care, as part of a federally determined essential benefits package. Grandfathered plans (those in existence on March 23, 2010) in those markets, however, will not have to comply with the standard. The benefits package will be similar to packages offered through employer plans and will include, at a minimum:

- ambulatory patient services;
- emergency services;
- hospitalizations;
- mental health and substance use disorder services, including behavioral health;
- prescription drugs;
- rehabilitative services and devices;
- laboratory services;

- preventive services, including services recommended by the Task Force on Clinical Preventive Services and vaccines recommended by the director of the Centers for Disease Control and Prevention; and
- chronic disease management.

In addition, the plans must cover pediatric services, including vision and oral care.

Insurance Exchanges and Subsidies of Premiums and Out-of-Pocket Costs (2014)

Women who do not have health insurance coverage through an employer and who earn incomes too high to qualify for Medicaid (more than \$14,404 for an individual and \$29,327 for a family) will be eligible to gain coverage through new state insurance exchanges beginning in 2014. Women who own small businesses with fewer than 50 or 100 employees, depending on the state, will also be able to purchase a health plan through the exchange.³⁶ The individual and small-group markets will continue to function outside the exchange, but new insurance market regulations will apply to plans sold inside and outside the exchange.

Women buying insurance through the exchanges will have far better information about what health plans cover than they do today when buying coverage on their own. Women purchasing coverage through the exchanges can choose a plan with the essential benefit package at one of four cost-sharing levels: bronze (covering an average of 60% of an enrollee's medical costs), silver (70%), gold (80%), and platinum (90%). For all plans, out-of-pocket costs are limited to \$5,950 for single policies and \$11,900 for family policies.

In addition, adults under age 30 who are not eligible for subsidized coverage and anyone who cannot find a plan with a premium that costs 8 percent or less of their income will have the option of purchasing a so-called catastrophic health plan. These plans will include the essential benefit package, as well as three primary care visits per year, but their cost-sharing could be similar to high-deductible, health saving account-eligible plans. Preventive services will be excluded from the

deductible, as under current law, and cost-sharing will be limited to the current health savings account out-of-pocket limits, as would the rest of the plans offered through the exchange (\$5,950 for single policies and \$11,900 for family policies).

For the first time, women buying coverage on their own will be eligible for a subsidy to help pay the cost of premiums for plans sold through the exchanges. Premium credits, which will be tied to the silver-level plan, will cap premium contributions at about 3 percent of income for individuals and families with income at just over 133 percent of the poverty level (\$14,404 for a single adult and \$29,327 for a family of four) (Exhibit 2). The cap will gradually increase to 9.5 percent of income at 300 percent to 400 percent of poverty (\$43,320 for a single person, \$88,200 for a family of four). With these subsidies, up to 41 percent of nonelderly adult women who are uninsured—7 million women—could gain coverage.³⁷

Women with low or moderate incomes will also benefit from cost-sharing credits that effectively reduce out-of-pocket costs under the silver plan from 30 percent of total medical costs to 6 percent for those living at 150 percent of poverty. Costs will drop to 13 percent of total costs for those with incomes up to 200 percent of poverty, and to 27 percent for incomes up to 250 percent of poverty. In addition, for people earning between 100 percent and 400 percent of poverty, out-of-pocket expenses will be capped for individuals at \$1,983 to a maximum of \$3,967, and for families at \$3,967 to \$7,933.

About 1.6 million women who currently are uninsured, or about 10 percent of all uninsured adult women, earn too much to be eligible for premium subsidies. But these women will still benefit from the essential benefit package, from having clear information about what plans cover and what their cost-sharing responsibilities are, and from new consumer protections that prevent carriers from denying coverage or charging higher premiums based on health or gender.

In addition, the essential benefit package, consumer protections, out-of-pocket limits, and cost-

sharing subsidies also promise to substantially help the estimated 14.5 million women who are underinsured.

Restrictions on Use of Federal Funds for Abortion Services (2014)

The new health reform legislation contains restrictions on the use of federal premium and cost-sharing subsidies for abortion services. In keeping with a long-standing federal law commonly known as the Hyde Amendment, the ACA prohibits federal funds from being used for abortion services, except in the case of rape, incest, or when a woman's life is endangered.³⁸ The restrictions on federal funding apply to subsidized plans sold through the health insurance exchanges, the expansion of Medicaid eligibility, and the Community Health Center Fund, which will provide additional federal funds for the federal community health center program.

The ACA requires that the exchanges follow strict payment and accounting procedures to ensure that premium and cost-sharing tax credits are not used for abortion services, except as allowed by the Hyde Amendment. People eligible for subsidies for plans sold through the exchanges will pay only one premium, but federal and state regulators must segregate part of the premium (that which is not subsidized with federal dollars) into an account to be used exclusively for abortion services not allowed under the Hyde Amendment. Insurers selling plans in the exchanges can decide whether they will offer any abortion services and are required to include in their benefit descriptions whether or not they cover abortion, as they will do for all other benefits. The allocation of the premium into its components will not be advertised or used in enrollment material. All applicants will see the same premium when they are choosing a plan.

In addition, the ACA allows states to prohibit abortion coverage in qualified health plans offered through an insurance exchange if the state enacts a law that requires such a prohibition.

Penalties on Employers for Not Offering Health Insurance or Offering Benefits of Low Quality (2014)

The ACA imposes penalties on large employers that do not offer coverage or offer health insurance of poor quality. Although most large employers offer health benefits to their employees, some women who work for companies that do not offer benefits might gain coverage, as may their spouses. And some women who have employer-provided health plans with skimpy benefit packages, high premium contributions, or high cost-sharing may become eligible for federally subsidized coverage through the exchanges.

Under the ACA, firms that employ 50 or more full-time-equivalent workers and do not offer health insurance must make a payment of \$2,000 for each full-time employee (those working more than 30 hours per week) who becomes eligible for a premium subsidy through an exchange. The penalty does not apply to the first 30 full-time workers in a company. If a firm employing at least 50 full-time-equivalent workers does offer coverage but a full-time worker is deemed eligible for premium subsidies through the exchange—either because her premium contribution exceeds 9.5 percent of income or her coverage does not meet the “minimum creditable” benefit standard (plan covers at least 60 percent of an enrollee's costs)—then the company must pay the lesser of \$3,000 for each full-time worker who receives such a premium subsidy through the exchange, or \$2,000 for each full-time employee.

The CBO estimates that as a consequence of the ACA's employer penalties and individual requirement to have health insurance, about 6 million to 7 million more people will have coverage through employers.³⁹ Many women who are working in jobs in which they do not have health insurance may gain employer benefits, as may their spouses. At the same time, the CBO estimates that 8 million to 9 million workers—mostly those in small, lower-wage firms—will *lose* their job-based coverage, as their companies decide that employees can gain similar, subsidized coverage through the insurance exchanges.⁴⁰ Those affected will include women and their spouses.

Finally, women who are enrolled in an employer-provided health plan and who spend more than 9.5 percent of their income on premiums, or who have health plans with substantial cost-sharing obligations (i.e., the plan covers less than 60 percent of their total medical costs), may become eligible for subsidized coverage with better benefits and lower out-of-pocket spending through the insurance exchanges.

Individual Requirement to Have Health Insurance (2014)

Beginning in 2014, all U.S. citizens and legal residents will be required to maintain minimum essential health insurance coverage through the individual insurance market or an insurance exchange, a public program, or their employer, or face a penalty. There are some exemptions: individuals who cannot find a health plan at a cost of less than 8 percent of their income, net of subsidies and employer contributions; people who have incomes below the tax-filing threshold (\$9,350 for an individual and \$18,700 for a family); those who have been without insurance for less than three months; and individuals with certain other circumstances, such as religious objections.

People not exempt from the mandate who cannot demonstrate on a tax form that they have health insurance will be required to pay a penalty equal to the greater of \$95 or 1 percent of taxable income in 2014, \$325 or 2 percent of taxable income in 2015, and \$695 or 2.5 percent of taxable income in 2016, up to a maximum of three times that amount per family, or \$2,085.

The individual requirement to have health insurance has been a controversial feature of the health reform law, but it is critical for achieving near-universal coverage for women and their families. The mandate will ensure that the new health insurance exchanges

and the individual and small-group markets will provide coverage to both younger and older people and to healthy and less-healthy people. This will help maintain the affordability of premiums over time. Without the requirement, the exchanges and insurance markets would be predominantly used by those who are older or sicker, while younger and healthier people might delay buying health insurance until they need it. Indeed, the CBO estimates that the influx of young and healthy people into the exchanges and individual markets in 2014 will lower premiums by 7 percent to 10 percent from projected levels.⁴¹

Conclusion

The Affordable Care Act promises a dramatic expansion and improvement of insurance coverage for millions of American families over the next decade. Up to 15 million adult women who are now uninsured could receive subsidies to help pay for comprehensive coverage under the law. An additional 14.5 million underinsured women will have improved coverage. And women who have an individual insurance market policy that charges them higher premiums than it does for men, who have been unable to secure coverage for the cost of pregnancy, or who have a preexisting health condition excluded from their benefits will ultimately find themselves on a level playing field with men, with a full range of comprehensive benefits, including maternity coverage.

Over the next decade, the ACA is likely to stabilize and reverse the growing exposure to health care costs that women have experienced over the last decade, ensuring that women and their families can get the health care they need without the risk of incurring catastrophic medical bills.

NOTES

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- ¹⁷ Ibid.
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- ²¹ Ibid.
- ²² The PCIPs were originally called national high-risk pools in the ACA. They are modeled in part on state high-risk pools that exist in 35 states and cover about 200,000 people. Most states impose premium caps for their high-risk pools, ranging from 125 percent of average individual market rates in Minnesota and Oregon to as high as 250 percent in Florida. There is tremendous variation in what the plans cover, as well as in the deductibles and maximum annual and lifetime benefit limits. Most states impose waiting periods for preexisting conditions. Enrollment also varies widely, with only 300 people in the pool in Florida compared with 27,386 people in Minnesota. Even though premiums in high-risk pools are high, they have not been sufficient to finance the expensive claims made in these pools. See National Association of State Comprehensive Insurance Plans, *Comprehensive Health Insurance for High Risk Individuals: A State by State Analysis*, 2009/2010.
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- ²⁴ These are: Alabama, Arizona, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, Nebraska, Nevada, North Dakota, South Carolina, Tennessee, Texas, Virginia, and Wyoming. See <http://www.pcip.gov/StatePlans.html> for more information about the federal PCIP.
- ²⁵ Congressional Budget Office, Letter to the Honorable Michael B. Enzi, June 21, 2010.
- ²⁶ Department of the Treasury, Department of Labor, and Department of Health and Human Services, *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act*, July 19, 2010, available at <http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=24044>.
- ²⁷ For a complete list, see the publication listed in note 26 above, Section V, pp. 49–65.
- ²⁸ Most plans have some variant of the “standard” benefit, with many offering lower or no deductibles and alternative cost-sharing, and some offering coverage of at least some, usually generic, drugs when the coverage gap has been reached.
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- ³⁶ Under the ACA, states can open their exchanges to companies with 100 or fewer workers. Until 2016, states can opt to limit participation to companies with fewer than 50 employees. Starting in 2017, states have the option to allow companies with more than 100 employees to buy plans through the exchange.
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