What Women Are Getting From Health Reform
The Top Ten List
Plus Two Bonus 2011 Additions

1. **All new insurance plans are required to cover preventive health care without imposing any additional costs, like co-payments, on policyholders.** The ACA requires all new private insurance plans to cover preventive health services without any cost-sharing (like co-payments, coinsurance and deductibles for all expenses that must be met before coverage kicks in). In the first phase of this change, the list of covered preventive health care included many important services for women like mammograms and screenings for cervical cancer and sexually transmitted infections. Starting no later than August 2012, the same requirement will apply to eight additional women's health services which have been identified as critical preventive health services for women by medical experts at the Institute of Medicine (IOM). The services to be added include contraception, breastfeeding supports and screening for gestational diabetes, HIV infection and domestic violence.

   Timing: The first phase of this provision went into effect on September 23, 2010, for all newly issued plans and for existing plans which have changed substantially. The requirement for coverage without co-pays of the additional women's preventive health services recommended by the IOM will go into effect no later than August 2012.

2. **Insurance companies are prohibited from canceling the policies of people who get sick.** As a result of the Affordable Care Act (ACA), insurance companies can no longer cancel the policies of women who develop breast cancer or other serious illnesses, a practice known as rescission. Insurers are also prohibited from canceling your policy because of an unintentional mistake on your paperwork. In the past, insurance companies could search for an error or technical mistake in your application and use it to deny payment for services. The law now makes this illegal; the only way that a policy can be canceled is if the insurance company can prove intentional fraud. If insurers want to rescind coverage, they have to provide at least 30 days advance notice to give people time to appeal the decision.

   Timing: Some families were able to start taking advantage of this new protection in 2010. For others, it is new this year. The effective date for this section of the law is linked to the date when your new health plan year starts. If you have job-based coverage, your plan year will begin on the date that the policy is renewed or the date that your employer buys a new policy. If you've purchased a policy on your own in the individual market, the policy year may begin on the anniversary date of when you bought the policy, the date that the plan begins calculating your annual expenses to meet a deductible or the beginning of the calendar year.

3. **Insurance companies can no longer set lifetime limits or "unreasonable" annual limits on the amount of medical care they will cover under existing policies**. The ACA prevents insurance companies from setting lifetime limits on the dollar amount of health care they will cover, and then ending your coverage when you hit that limit. Insurers are also restricted from setting "unreasonable" annual limits on the amount they will cover under your existing policies. These

limits had left women facing treatment for serious illnesses, such as ovarian cancer, with the added burden of major medical debt from paying the cost of treatment beyond the insurer's limits.

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4. **Dependent children can stay on their family policies until their 26th birthdays, unless they get coverage through their employers.** Families can help adult children maintain health insurance by keeping them on the family health insurance policy until age 26. Young adult children whose employers don't offer insurance are eligible to stay on family policies, even if they are no longer students, no longer live at home, are financially independent or are married (although their spouse cannot be covered). This provision is especially important for young women who need affordable coverage for contraception, maternity care, abortions and screening for/treatment of sexually transmitted infections (STIs).

   ***Timing*:** This provision applies to insurance policies starting at the beginning of the first plan year after Sept. 23, 2010. That means that most families are already benefitting from this improvement.

5. **Women with high prescription drug expenses who are on Medicare Part D are paying less for their medications.** Seniors whose prescription drug expenses are high enough to put them into the non-reimbursed "donut hole" are getting discounts and rebates to decrease how much they have to pay out-of-pocket. The "donut hole" refers to the situation encountered by people who have Medicare Part D coverage and have exceeded the initial coverage limit of $2,830 in drug costs, forcing them to pay out of pocket for prescriptions. Last year, seniors who fell into the donut hole got $250 rebates; in 2011 drug companies have to give them 50 percent discounts on brand-name drugs and cheaper prices for generic drugs as well. AARP says this could reduce costs for typical Medicare beneficiaries by $700, and the National Council on Aging estimates that some seniors will save as much as $1,800. The discounts will increase over time until 2020 when the donut hole will be closed completely.

6. **You have a streamlined choice of health care providers and get easier access to them.** You are now guaranteed the right to choose any available participating primary care provider for yourself or your families and any available participating pediatrician for your children. Importantly, now insurance companies cannot require women to get a referral for ob/gyn care.

   ***Timing*:** These policies (including the elimination of ob/gyn referrals) went into effect on September 23, 2010, for all newly-issued plans and for existing plans which have changed substantially.

7. **Small employers with low-wage workers (under $50,000) are eligible for tax credits to help them buy health coverage for employees**. Whether you work for a business or a non-profit, if your employer has fewer than 25 employees, it may qualify for a tax credit of up to 35 percent for small businesses and up to 25 percent for non-profits to help with the costs of providing employee health insurance. This provision is especially important for women, many of whom work for small businesses or non-profits.

8. **Children with pre-existing conditions cannot be denied coverage**. Employer-based health plans and new individual plans are no longer allowed to deny or exclude coverage for your children if they are under age 19 and have a pre-existing condition and/or a disability.

   ***Timing*:** This protection went into effect on September 23, 2010, for new plans and existing group plans. Starting in 2014, these plans won't be allowed to deny coverage for anyone (including adults) or charge them more for a pre-existing condition, including a disability.

9. **Adults with pre-existing conditions have new, more affordable coverage options through "high-risk" pools (or Pre-Existing Condition Insurance Plans, PCIPs)**. HHS has worked with individual states to establish temporary high-risk pools that provide health coverage to individuals with pre-existing medical conditions. The PCIPs provide a new option for people who have been uninsured for at least six months, have been unable to get health coverage because of a health condition, and are U.S. citizens or are residing in the United States legally. Unfortunately, these plans do not include abortion coverage, except in cases of rape, incest or threat to the woman's life. For more information on how to apply, go to www.healthcare.gov/law/about/provisions/pcip/index.html and click on your state. Starting in 2014 when the health insurance exchanges begin operations, the PCIPs will no longer be necessary because people who were previously denied insurance because of pre-existing conditions will be able to get insurance from all plans participating in the exchanges.

10. **People who retire before they are old enough to qualify for Medicare can get more affordable health coverage through a new reinsurance pool.** In order to provide employer-based coverage for early retirees until more affordable coverage is available through the new insurance exchanges in 2014, the ACA created a new reinsurance pool. This is a $5 billion program that helps employment-based plans continue to provide coverage to people who retire between the ages of 55 and 65, as well as their spouses and dependents. This is particularly important to women who are more likely to have dependent coverage and often lose that coverage between the ages of 55 and 65 due to divorce or the death of a spouse.

    ***Timing*:** Applications for employers to participate in the program were made available on June 1, 2010. For the latest updated FAQ information regarding this provision please see here: http://www.hhs.gov/ociio/Documents/application_faq.html.

Bonus Additions – New in 2011

11. **Older women insured through Medicare have better access to primary and preventive care.** People enrolled in Medicare can get many preventive health services – like vaccinations, colorectal cancer screenings and mammograms – without paying charges like copayments or deductibles. They also can get a free annual wellness exam where a physician will help them create a personalized prevention plan. In just the first two months of 2011, more than 150,000 Medicare beneficiaries did! In addition, the ACA increased Medicare payment rates for primary care providers – not just physicians, but also nurse practitioners, physician assistants and nurses -- to give them a greater incentive to see Medicare patients in their practices.

12. **Insurers have to spend more of the money they collect on your medical care and less on CEO salaries, marketing and overhead.** The ACA requires insurance companies to give rebates to consumers if they don't spend at least 80 percent of the premium dollars they collect for individual policies on actually providing medical care. For policies sold to large employers, the requirement is 85 percent. The law also requires insurance companies to make this information public. This will make it easier for women shopping for health insurance for their families to choose the plan with the best value because they will have meaningful information about how each company is spending

consumers' premium dollars and will be able to find out which companies met the minimum requirement, which did better than the minimum and which failed.

Timing: The spending requirements went into effect in 2011, but the rebates won't go out until 2012. According to estimates, about 9 million people are likely to be eligible for rebates.

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More factsheets available on the Raising Women's Voices website

www.raisingwomensvoices.net/rwv-publications/

- **Affordable Preventive Health Care for Women**
- **Fast Facts: Young Adults and Health Reform**
- **Health Care Reform: What Young Adults Should Know**

ADDITIONAL RESOURCES

Commonwealth Fund- Realizing Health Reform's Potential: Women and the Affordable Care Act of 2010
www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Jul/1429_Collins_Women_ACA_brief.pdf

Community Catalyst- Who is the Affordable Care Act helping in your community?
http://www.communitycatalyst.org/doc_store/publications/Who_ACA_is_helping.pdf

Families USA- Worry Less Spend Less: Out-of-Pocket Spending Caps Protect America's Families
www.familiesusa.org/resources/publications/reports/health-reform/out-of-pocket-caps-states.html

Kaiser Family Foundation- Health Reform Implementation Timeline
healthreform.kff.org/timeline.aspx

National Women's Law Center- The Health Care Litigation: What Women Could Lose
www.nwlc.org/resource/health-care-litigation-what-women-could-lose

GOVERNMENT RESOURCES

HealthCare.gov
Provides consumers with state-by-state information about coverage options and explanatory materials on the health reform law and its implementation.
www.HealthCare.Gov

Centers for Medicare and Medicaid Services Health Reform Center
http://www.cms.gov/Center/healthreform.asp

Department of Labor
Provides information on aspects of the health reform law relating to employer-provided health benefits including implementation, claims and appeals, compliance and much more.
http://www.dol.gov/ebsa/healthreform/

Internal Revenue Service
Regulations and guidance relating to health reform changes to the tax system, including subsidies for insurance premiums and tax credits for small employers.
http://www.irs.gov/newsroom/article/0,,id=222814,00.html