

By Jennifer Breshears Wheeler and Austin Rueschhoff

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The National Conference of State Legislatures seminar, “Improving Women’s Health: Opportunities and Challenges of Health Reform,” was held in November 2011 at the NCSL Fall Forum. The seminar, which featured speakers who covered a range of topics, concluded with a discussion among state legislators and legislative staff about women’s health and the federal Affordable Care Act (ACA) of 2010. With the help of a bipartisan group of policymakers, NCSL developed this publication, which discusses women’s health and opportunities and challenges of the federal law.

The ACA makes several changes to public programs, insurance and other aspects of health policy that affect women. Overall, the law presents a variety of opportunities and challenges for states. By January 2014, the law requires individual health insurance coverage, expands Medicaid and requires health benefit exchanges to help low-income people obtain coverage. These broad components of health reform are expected to provide health coverage to 32 million uninsured people, including many women.

Although several initiatives within the law have the potential to improve women’s health, support for the law varies widely and substantial disagreement exists among state policymakers. Seminar participants generally recognized that, because approximately 50 million Americans lack health insurance and health care costs continue to rise, the health care system cannot be sustained as it currently exists. Overall, state policymakers agree that they not only want to support the principles of federalism, but also to maintain flexibility and control of programs so they can craft options that meet the needs of their state and the populations it serves.

Although most states have moved forward to implement ACA provisions required under the law’s deadlines, many have challenged specific ACA provisions. Challenges to the law are underway across the nation in the form of legislation, court cases, ballot initiatives and executive powers. Some reasons for opposition to the ACA include a fundamental question about its constitutionality, the issue of unfunded mandates for states, costs of expanding Medicaid, the requirement to create health insurance exchanges, or the individual mandate that will enforce tax penalties against those who do not obtain health insurance. In addition, states await a U.S. Supreme Court ruling, expected in early summer 2012, on the constitutionality of the individual mandate and expansion of Medicaid.

This publication highlights various ACA provisions related to coverage and access to care, maternal and reproductive health, and public health and wellness. It also identifies the key federal provisions and the opportunities and challenges they pose for states. For more information, visit [www.ncsl.org/?TabId=24039](http://www.ncsl.org/?TabId=24039) or e-mail [health-info@ncsl.org](mailto:health-info@ncsl.org).



## OVERALL OPPORTUNITIES FOR STATES

- An emphasis on prevention to promote healthy lifestyles and personal responsibility among state residents and to encourage a greater focus on prevention among health care providers.
- Greater access to insurance coverage for women (through the exchanges and Medicaid).
- More consumer-friendly policies for health insurance (e.g., coverage for pre-existing conditions).
- A focus on investing in preventive care, especially programs that are evidence-based, in an effort to save on future health costs (e.g., investment in the Prevention and Public Health Fund).

## OVERALL CHALLENGES FOR STATES

- Initial overall increase in health costs for states (most notably due to the Medicaid expansion, especially for new enrollees who will not qualify for the enhanced federal match).
- Increased administrative burden to states (e.g., costs and complexities of setting up insurance exchanges).
- Ambiguity and delay in guidance from federal agencies.
- Recruiting, educating, improving and maintaining an adequate number of health care providers to serve all those newly insured in 2014.
- Ensuring that high-quality care is offered and maintained, with measureable results.
- Encouraging individuals to take personal responsibility for their behaviors and health services.

## COVERAGE AND ACCESS TO CARE

The ACA will increase access to insurance coverage for many women by 2014 through insurance exchanges and Medicaid expansion requirements. However, states face many challenges related to planning for the insurance exchanges, expanding their Medicaid programs, and ensuring that the exchanges and Medicaid programs are integrated for eligibility determination and enrollment procedures. In addition, starting in 2014, millions of the newly insured will

seek medical care in a primary care setting, placing an even greater strain on the primary care workforce.

## CHANGES IN PLACE

- **Coverage of preventive care.** As of Sept. 23, 2010, the law prohibits new or modified insurance plans from imposing copayments or coinsurance for certain preventive services, including evidence-based items or services that have an 'A' or 'B' rating by the U.S. Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices, and preventive care and screenings contained in guidelines supported by the Health Resources and Services Administration specific to women and children. Note: effective Jan. 1, 2013, states will receive a 1 percentage point increase in federal Medicaid matching payments for certain recommended immunizations and services that receive an A or B rating from the USPSTF and for which states do not charge a copayment.
- **Institute of Medicine (IOM) recommendations specific to women.** The IOM released recommendations to the U.S. Department of Health and Human Services (HHS) related to additional preventive services to be covered specifically for women; these were adopted by HHS as formal regulations in August 2011. The recommendations include well-woman visits, coverage for contraception, breastfeeding support, and domestic violence screening and counseling. New (and changed renewing) health plans will be required to cover these services without cost-sharing, beginning in August 2012.

## CHANGES TO BE IMPLEMENTED BY 2014

- **Medicaid expansion.** The law expands Medicaid to all Americans under age 65 whose family income is at or below 133 percent of federal poverty guidelines (\$14,856 for an individual and \$30,657 for a family of four in 2012) by Jan. 1, 2014. As the Medicaid expansion goes into effect in 2014, states must use Modified Adjusted Gross Income (MAGI) for eligibility determination, which eliminates resource tests and applies a 5 percent income disregard, effectively raising the eligibility level to 138 percent of federal poverty guidelines for most applicants. Full federal financing (100 percent Federal Medical Assistance Percentages—FMAP) will be available for those newly eligible for Medicaid for three years (2014 through 2016). The FMAP scales back to 95 percent in 2017, to 94 percent in 2018, to 93 percent in 2019, and to 90 percent in 2020 and beyond; the law calls for states to pick up the balance.



Childless adults will make up a significant percentage of this newly eligible population, including many women.

- **Establishing exchanges.** The ACA requires that, by Jan. 1, 2014, states have a fully functional health benefit exchange that facilitates insurance purchasing through qualified health plans and a Small Business Health Options Program (SHOP). Premium assistance will be provided through federal financing for families with incomes up to 400 percent of the federal poverty guidelines to help them purchase insurance coverage within the exchange. States may establish and operate one or more exchanges, join with another state or states to do so, or partner with or defer to the federal government to establish and operate the exchanges in the state.
- **Essential health benefits.** The ACA requires all plans in the state health insurance exchanges to cover certain essential health services, specifically requiring plans to include maternity and newborn care. The law also required HHS to determine other essential benefits that must be covered by insurance plans in the exchanges. In December 2011, HHS issued a bulletin indicating that states will be able to select among certain existing insurance plans that operate within their own state, which will determine the additional essential benefits that must be covered by insurance plans in the exchange. States may choose from one of the three largest (a) small group plans; (b) state employee health plans; (c) federal employee health plan options or the largest HMO plan offered within the state's commercial market. HHS in-

tends to assess the process for the year 2016 and beyond based on evaluation and feedback.

- **Pre-existing conditions.** Beginning in 2014, the law prohibits health insurers from denying or dropping coverage for people with pre-existing health conditions. The law also prohibits insurers from establishing rules for eligibility based on certain health factors, including conditions caused by domestic violence.
- **Gender rating.** The law prohibits insurers from using gender rating, a practice under which women are charged higher premiums based solely on their gender.

## PRIMARY CARE WORKFORCE INITIATIVES

- **Grant programs to train primary care workforce.** The ACA includes provisions that intend to expand the primary care workforce to help meet the needs of the millions of newly insured. The Personal and Home Care Aide State Training Program and the Nursing Assistant and Home Health Aide Program are designed to create curriculum and training to increase participation in science-based training programs or undergraduate work. Another program within the ACA offers payments to eligible health centers to cover the costs of primary care residency training. In September 2010, HHS awarded \$253 million to states from the Prevention and Public Health Fund of the ACA to support comprehensive workforce planning and implementation strategies that best address local, current and projected workforce shortages.
- **Financial assistance for students interested in primary care.** The ACA extends financial assistance for health sciences students who are interested in primary care by providing workforce development grants and tax incentives for practicing in underserved areas. It expanded the National Health Service Corps program by \$1.5 billion over five years.
- **Payment reform for primary care providers.** Research shows that the income gap between primary care and specialty physicians deters health science students from pursuing a career in primary care. The ACA increases Medicaid payments for primary care services to match the required payments for similar services under Medicare in 2013 and 2014, using 100 percent federal funding. In subsequent years, state Medicaid programs will need to decide whether to maintain the elevated level of Medicaid reimbursement.

## OPPORTUNITIES FOR STATES

- **Increased access.** Many more women in the state will have access to health insurance through both the exchanges and Medicaid.
- **Preventive service coverage.** Certain preventive services are included in insurance plans without cost-sharing, which may allow more people with coverage to receive preventive services, such as mammograms.
- **Increasing the primary care workforce.** With the ACA initiatives, states have an opportunity to increase the number of primary care providers working in their state, especially in rural and underserved areas.

## CHALLENGES FOR STATES

- **Medicaid costs.** Expanding Medicaid may be the most pressing of the many funding issues related to the ACA that states face. Before states can estimate the cost of expansion, they must determine the number of people who currently are eligible for Medicaid but not enrolled. These currently eligible people will not qualify for the enhanced match provided for the “newly” eligible population. When the individual mandate to obtain health insurance becomes effective on Jan. 1, 2014, many will discover their Medicaid eligibility and will choose enrollment as their most economical option. States will receive their traditional federal match for this group, which ranges from 50 percent to 80 percent, significantly lower than the enhanced match for the “newly eligible.” As a result, many states will find the cost of their Medicaid programs will be higher. (During the discussion, it was noted that nearly 70 percent of Medicaid funding goes to services for the elderly and people with disabilities, including long-term care.)
- **Complications and costs of creating exchanges.** Establishing an exchange requires a great deal of planning, and many states already have started the process of creating their exchange. However, some are concerned that, when the exchanges are in place, employers may drop previously covered individuals in tough budget times.
- **Provider shortages.** Even with an increased effort to recruit and retain primary care providers, it still may be a challenge for states to maintain the workforce, especially in rural areas, at levels to serve all the newly insured in 2014. In addition, low reimbursement rates under Medicaid are likely to remain a challenge for existing providers.

## MATERNAL AND REPRODUCTIVE HEALTH

The ACA contains various initiatives that specifically address maternal and reproductive health, including breastfeeding support and Medicaid coverage for family planning services. In addition, increased access to insurance that includes coverage for maternity, prenatal and preventive care is likely to both allow more women to receive these services and result in improved rates of healthy babies at birth.

### CHANGES IN PLACE

- **Breastfeeding support.** The law amends the Fair Labor Standards Act to require employers to provide “reasonable” break time (but not compensation) in a place other than a bathroom, for an employee to express breast milk as often as needed for her nursing child for one year after the child’s birth. If these requirements impose undue hardship, employers with fewer than 50 employees are not subject to them. The ACA’s provisions do not preempt related state laws that specify additional requirements.
- **Family planning services.** State Medicaid programs are required to cover family planning services, for which the federal government pays 90 percent. Through waivers, states have been able to extend family planning services to certain people who are otherwise ineligible for Medicaid, such as women who will lose eligibility soon after giving birth. The ACA gives states additional flexibility to extend family planning services by allowing them to amend their state Medicaid plan, which eliminates the need to apply for or renew a waiver.



- **Freestanding birth centers.** The law requires Medicaid to reimburse providers who administer prenatal labor and delivery or postpartum care in a freestanding birth center, such as nurse midwives and birth attendants who are recognized under state law. This provision took effect upon enactment, except in states where such provisions are not authorized. Guidance released in March 2011 clarified that, to comply with this provision, states need to submit amendments to their Medicaid state plans that specify coverage and reimbursement of freestanding birth center facilities and professional services.
- **Home visiting.** The law established the Maternal, Infant and Early Childhood Home Visiting program, which provides grants to states to use on voluntary, home-based services for expecting and new parents. The program provides \$1.5 billion in grants over five years—ranging from \$100 million for FY 2010 up to \$400 million for FY 2013 and FY 2014. Of these funds, 75 percent must be used for federally approved evidence-based models, and up to 25 percent may be used for promising models and new approaches.
- **Nurse-midwives.** Certified nurse-midwives are to be reimbursed at 100 percent of the Medicare physician fee schedule (up from the previous 65 percent) for Part B services under Medicare.
- **Pregnancy Assistance Fund.** The law establishes the Pregnancy Assistance Fund with annual appropriations of \$25 million from 2010 to 2019. Funds are awarded to states competitively and passed through to eligible state agencies, institutions of higher education, high schools, community service centers, and state attorneys general in order to assist statewide offices. In September 2010, HHS awarded \$24 million to 17 states and tribes. These funds may be used for pregnant and parenting student services at schools, statewide offices that provide social services for pregnant women who are victims of domestic or sexual violence, and public awareness and education about services available to pregnant and parenting teens and women.
- **Smoking cessation services for pregnant women.** The law requires Medicaid to cover, without cost-sharing, any counseling and prescription drugs needed by pregnant women to quit smoking.

## CHANGES TO BE IMPLEMENTED BY 2014

- **Increased coverage for women of reproductive age.** As the exchanges become operational and Medicaid is expanded, more women are likely to have access to insurance coverage.
- **Abortion provisions in the insurance exchanges.** The law and the related White House executive order contain new provisions related to insurance coverage of abortion in state exchanges. The law maintains current Hyde Amendment restrictions that prohibit the use of federal funds for abortion services (except in cases of rape or incest or when the life of the woman would be endangered) and extends these restrictions to the health insurance exchanges. The law allows states (through legislation) to prohibit abortion coverage in all health plans offered through an exchange or, if insurance coverage for abortion is included, any policyholder who wants such coverage must pay a separate premium.

## INITIATIVES WITHOUT CURRENT FUNDING

- **Postpartum depression.** The law contains an initiative to expand research related to postpartum depression and enable the director of the National Institute of Mental Health to conduct a study of the mental health consequences of pregnancy for women—whether the pregnancy ends in giving birth, miscarriage or abortion. Although funding was authorized for this initiative, no funds have been appropriated to date.

## OPPORTUNITIES FOR STATES

- **Family planning services.** States may extend family planning services to certain women who would otherwise not qualify for Medicaid by amending their state Medicaid plan, which eliminates the need to apply for or renew a waiver; these services receive a 90 percent match from the federal government.
- **Home visiting.** The federal home visiting initiative provides an opportunity for states to increase coordination among home visiting programs, identify communities most in need of services, expand services to children and families most at-risk, identify desired program results, and potentially lower future health costs.
- **Pregnancy Assistance Fund.** States have an opportunity to support pregnant and parenting women with these funds, as described earlier.

- **Smoking cessation.** Women who smoke and have Medicaid coverage may have improved rates of healthy babies at birth with access to smoking cessation services without any additional costs.

## CHALLENGES FOR STATES

- **Breastfeeding support.** These requirements may be costly to employers, although exemptions are available to small employers related to cost.
- **Postpartum depression.** Funding currently is not available to address this issue. It is also unclear how mental health parity laws will affect this issue.

## PUBLIC HEALTH AND WELLNESS

The ACA contains numerous provisions to reduce the burden of chronic diseases, emphasize public health and promote women's health, including initiatives to support wellness programs in the community and workplace and to require insurance coverage for preventive services such as immunizations. These initiatives in the ACA demonstrate an effort to encourage a healthy lifestyle early on and promote wellness throughout the lifespan.

## PROGRAMS AND INITIATIVES CURRENTLY IN PLACE

- **Immunizations.** The law requires coverage of vaccines as a preventive service, requiring new and modified renewed insurance policies to cover, without cost-sharing—such as copayments or coinsurance—immunizations recommended by the national Advisory Committee on Immunization Practices (ACIP). The ACIP is a group of 15 health experts, appointed by the U.S. secretary of Health and Human Services, who recommend vaccine schedules for children, adolescents and adults. As an incentive for states to cover preventive services—including adult vaccines—without cost-sharing requirements under Medicaid, the ACA also allows a 1 percent increase in the Federal Medical Assistance Percentage (FMAP)—also known as the federal Medicaid match—beginning in 2013 for



states that adopt this option, providing an increase of federal dollars in state Medicaid budgets. The ACA also modified section 317 of the Public Health Services Act and reauthorized its immunization grant program, which provides funding to all states and territories and six cities to make vaccines available for immunization programs. Previously, states could purchase only recommended childhood immunizations (e.g., vaccines to prevent polio, whooping cough and meningitis); now, however, the ACA authorizes states to purchase vaccines for adults as well (e.g., vaccines to prevent influenza and shingles). HHS can negotiate and contract with vaccine manufacturers for reduced rates on adult vaccines for state immunization programs.

- **Improving women's health.** The law charges the HHS Office on Women's Health with various objectives, including establishing a National Women's Health Information Center and a Coordinating Committee on Women's Health. The offices of women's health within various federal agencies must report on their activities related to women's health, establish women's health-related goals and objectives for their agency, identify women's health projects to be conducted or supported, consult with key partners to develop policies for their agency, and serve as a member of the Coordinating Committee on Women's Health. The first report to Congress was released in March 2011. Although funding was authorized for this initiative and some activity has occurred, no funds have been appropriated to date.
- **Incentives for prevention of chronic diseases.** On Feb. 25, 2011, HHS announced \$100 million in grants for states to provide incentives to Medicaid enrollees who adopt healthy behaviors, such as weight loss, smoking cessation, blood pressure and cholesterol control, or diabetes prevention or management. Ten states received this funding in 2011. The program will award \$100 million each year through 2015, subject to annual federal appropriations.

- **Insurance Wellness Programs.** The ACA permits employers to offer employees rewards of up to 30 percent of the cost of coverage for participating in a wellness program and making progress toward certain health-related goals such as weight control, smoking cessation, blood

pressure and cholesterol control, and diabetes management.

- **National Prevention Council and Strategy.** The law created the National Prevention, Health Promotion and Public Health Council to coordinate prevention efforts across 18 federal agencies. A draft framework on the National Prevention and Health Promotion Strategy was released June 16, 2011, which makes recommendations to help shift the nation's health system focus from treating sickness and disease to promoting wellness and prevention in order to help reduce preventable death and disability. The council, chaired by Surgeon General Regina Benjamin, will submit an annual progress report to Congress through 2015.
- **Prevention and Public Health Fund.** The law created this fund to invest in public health initiatives, health screenings and prevention research to improve health and help contain the rate of increase in private and public sector health costs. The fund allocated \$500 million in FY 2010, with \$250 million for investment in prevention—supporting activities to increase physical activity, improve nutrition, prevent smoking and tobacco use, and improve public health infrastructure—and \$250 million to fund training for new primary care providers. In FY 2011, the total Prevention and Public Health Fund appropriation was \$750 million and increased to \$1 billion for FY 2012. In 2011, more than \$100 million in funding was awarded to 61 states and communities nationwide for community transformation grants to support activities to reduce and prevent chronic disease by tackling its root causes such as smoking, poor diet and physical inactivity.

## PROGRAMS AND INITIATIVES WITHOUT CURRENT FUNDING

- **Breast cancer in young women.** The law creates a national, evidence-based public education campaign to be administered through the Centers for Disease Control and Prevention to increase young women's knowledge and awareness of breast health. The law calls for an advisory committee, an education campaign for physicians and other health care professionals, and prevention research on breast cancer in younger women. Grants are authorized for organizations and institutions to provide health information from credible sources and substantive assistance directed to young women diagnosed with breast cancer.

- **Healthy living.** The ACA established a five-year pilot program that awarded \$50 million in grants in FY 2010 to promote healthy living among people ages 55 to 64. Grants were awarded to state and local health departments and Indian tribes for public health community interventions to address nutrition, physical activity and tobacco use. Additional funding for 2011 through 2014 was authorized but not appropriated.
- **Immunization demonstration program.** The ACA established a demonstration program to award grants to states in FY 2010 to improve immunization rates in high-risk populations, including coverage for adults, adolescents and children. The program also will determine if access to vaccines is improved among Medicare enrollees. Funding for 2011 through 2014 was authorized but not appropriated.
- **Oral health initiatives.** The law extends oral health infrastructure grants to all states and requires that oral health components be included in the Pregnancy Risk Assessment and Monitoring System. The law also requires the CDC to establish a five-year oral health care prevention education campaign, subject to the availability of appropriations. The law authorizes a program providing grants to states to carry out research-based dental caries disease management programs and demonstrate program effectiveness.



## OPPORTUNITIES FOR STATES

- **Grant programs that benefit women.** The law contains several grant programs that offer an opportunity to improve public health that will affect women.
- **Shifting focus to prevention.** These initiatives focus additional resources and emphasis on disease prevention, which has the potential to save future health costs.

## CHALLENGES FOR STATES

- **Unfunded grant programs.** Funding is not currently available to support some of the grant programs in the law. In addition, funding for some programs that currently are in place may not continue if the federal budget is reduced.
- **Program costs and additional federal spending.** Although investments in prevention programs sometimes provide immediate health benefits and cost savings (such as fewer cases of influenza through immunization efforts or fewer hospital admissions for heart attacks resulting from smoke-free policies), others do not save health dollars up front and may not realize cost-savings for years. State budgets must be balanced each year, however, and federal budget negotiations continue to focus on deficit reduction.



## CONCLUSION

Several initiatives within the ACA potentially could improve women's health, including those related to coverage and access to care, maternal and reproductive health, and public health and wellness. States have opportunities and also face challenges related to ACA implementation, and support of the law varies widely among state policymakers. Even as most states have moved forward to implement ACA provisions, many states have challenged specific provisions of the law, and all states await a ruling on the law's constitutionality by the U.S. Supreme Court. NCSL will continue to foster a bipartisan discussion around the topic of women's health and provide state policymakers with information and technical assistance about implementation of ACA provisions.

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NATIONAL CONFERENCE OF STATE LEGISLATURES  
*The Forum for America's Ideas*

National Conference of State Legislatures  
William T. Pound, Executive Director

7700 East First Place  
Denver, Colorado 80230  
(303) 364-7700

444 North Capitol Street, N.W., #515  
Washington, D.C. 20001  
(202) 624-5400

[www.ncsl.org](http://www.ncsl.org)

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