Fact Sheet
Health Reform: What’s in it for Women?

AMCHP’s Role

AMCHP supports state maternal and child health (MCH) programs and provides national leadership on issues affecting women and children. We work with partners at the national, state and local levels to promote women’s health, provide and promote family-centered, community-based, coordinated care for women and children and facilitate the development of community-based systems of services for women, children and their families.

AMCHP’s National Center for Health Reform Implementation provides state MCH leaders and their partners with the information, tools and resources to optimize the opportunities presented by the Patient Protection and Affordable Care Act (ACA) for improving services, systems, and health outcomes for MCH populations.

Introduction

Providing quality health care for women is essential to improve women’s health. The opportunity to improve health via the Patient Protection and Affordable Care Act (ACA) will yield enormous public health benefits by establishing a system for a continuum of care tailored toward women’s unique reproductive and other health care needs whether or not they choose to become parents. Building systems to address women’s health care needs throughout the lifespan will go a long way to promote health, prevent many chronic diseases and improve birth outcomes. The ACA presents a significant opportunity for state maternal and child health (MCH) programs and their partners to improve the health care delivery system overall, promote women’s health and assure that they have access to quality health care.

Women’s Health Provisions in the Patient Protection and Affordable Care Act (ACA)

ACA contains numerous provisions that impact health programs and services for women. Additionally, the law includes several provisions targeting prevention including investments in tobacco cessation, teen pregnancy prevention and home visiting. The scope and impact of many of these provisions will unfold over the coming years as federal rules and regulations are promulgated and states and communities implement them. Highlights of key ACA provisions that affect women are below.

Coverage and Benefits

Medicaid Expansion. Creates a new mandatory Medicaid eligibility category for all individuals with income at or below 133 percent of the Federal Poverty Level (FPL), beginning January 1, 2014. Because half 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. Prescription drugs and mental health services are added
to the list of services that must be covered at actuarial equivalence. From 2014 through 2016, the federal government will pay 100 percent of the cost of covering newly-eligible individuals. In 2017 and 2018, states that initially covered less of the newly-eligible population (called “Other States”) will receive more assistance than those states that covered at least some non-elderly, non-pregnant individuals (“Expansion States”). ACA also requires comprehensive tobacco cessation services for pregnant women enrolled in Medicaid.

Insurance Exchanges and Subsidies. The bill sets up a state health insurance exchange to offer basic health programs for small businesses and uninsured individuals. Women who do not have health insurance coverage through an employer and who earn incomes between 133 to 400 percent federal poverty level—too high to qualify for Medicaid will be eligible to gain coverage through new state insurance exchanges beginning in 2014. These women will be able to obtain tax credits to subsidize premium costs.

Insurance Market Reforms. Includes several insurance market reforms including a ban on pre-existing conditions exclusions, no lifetime or unreasonable annual limits, prohibits discriminatory premium rates and provision for guaranteed availability of coverage. All plans sold on the individual market must cover essential services including maternity care.

Temporary High Risk Pool. Provides immediate access to insurance for women who are uninsured because of a pre-existing condition like pregnancy — through a temporary high-risk pool — until the state exchanges are operational. High risk pool will phase out beginning in 2014. The plans are operated by the states or the federal government.

Extended Coverage for Young Adults on Parent’s Plans. Requires that any group health plan or plan in the individual market that provides dependent coverage for children, to make that coverage available for young adults up to age 26 even if the young adult no longer lives with his or her parents, is not a dependent on a parent’s tax return, or is no longer a student. ACA and federal regulations also provide important tax credits to families by excluding the value of any employer-provided health coverage for an employee’s child from the employee’s income through the end of the taxable year in which the youth turns 26. According to Kaiser Family Foundation 29 percent of women between the ages of 19 and 25 are uninsured and could potentially benefit from this expansion.

Essential Benefits Package. Requires qualified health plans to include the following essential health benefits as part of a comprehensive benefits package: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

Preventive Care. Eliminates co-pays for services recommended by the United States Preventive Services Task Force (USPSTF) and immunizations recommended by the Centers for Disease Control and Prevention (CDC). The new law will also cover additional preventive health services for women not included in the USPSTF recommendations.

On August 1, 2011 the Health Resources and Services Administration (HRSA) issued guidelines to ensure that women have coverage for eight preventive health services identified by the Institute of Medicine (IOM) as critical gaps as well as measures to further ensure women’s health and well-being. The guidelines require new health insurance plans beginning on or after August 1, 2012, to cover these services without charging a co-payment, co-insurance or a deductible. These eight health services are:

- A well woman visit;
- Screening for gestational diabetes;
- Human papillomavirus (HPV) DNA testing for women 30 years and older;
- Sexually-transmitted infection counseling;
- Food and Drug Administration approved contraception methods and contraceptive counseling;
- Breastfeeding support, supplies and counseling;
- Human immunodeficiency virus (HIV) screening and counseling; and
- Domestic violence screening and counseling.
Family Planning. Following the release of the HRSA guidelines on women’s preventive services it is anticipated that all FDA approved contraceptive devices and contraceptives will be part of the essential health benefits package under the preventive services category. Medicaid already requires that states cover family planning services without cost-sharing. States that decide to offer newly eligible Medicaid enrollees a benchmark benefit plan must include coverage of family planning services to all qualifying individuals. Additionally, the ACA allows states to extend eligibility for family planning services to women with incomes below 185 percent of poverty without going through the federal waiver process. States can accomplish this by changing their Medicaid rules through a state plan amendment.

Prevention and Public Health


Maternal, Infant, and Early Childhood Home Visiting Programs. Creates a new section in Title V to provide $1.5 billion in mandatory funding over five years to states, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.

Support, Education, and Research for Postpartum Depression. Creates another new section to Title V that authorizes $3 million in grants to states for services to individuals with, or at risk, or postpartum depression and their families.

Breastfeeding. Amends the Fair Labor Standards Act of 1938 to require that employers provide a reasonable break time for an employee to express breast milk for her nursing child for one year after the child’s birth and provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public.

National Quality Strategy. Requires the Department of Health and Human Services to develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes and population health. ACA also creates a process to the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. In March 2011, the National Strategy for Quality Improvement in Health Care was released to Congress. The development of these measures will lead to quality improvement of maternity care.

Office of Women’s Health. Codifies the establishment of Offices of Women’s Health in major federal agencies, including the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, the Food and Drug Administration, the Health Resources and Services Administration and the Agency of Health Research and Quality. Also establishes a HHS Coordinating Committee and a National Women’s Health Information Center.

How can State Title V MCH Programs Optimize ACA for Women?

ACA represents a significant opportunity to improve access and health care for women. Yet, more work remains to be done. These and other ACA provisions will be implemented over the next several years with much of the responsibility for the architecture of health reform and its related program investments residing with states and
communities. As states proceed with implementing ACA, state MCH programs and their partners can assure that the law includes a focus on women through multiple strategies including the following.

**Ensure that the implementation of coverage provisions includes a focus on the needs of women.** Prevention, screening, diagnosis, and treatment of the array of physical, mental and behavioral health issues and conditions that concern women needs to be assured in the benefits package.

**Coordinate federal, state and local efforts in support of women’s health.** State MCH programs link uninsured women to available prenatal services, coordinate closely with state Medicaid programs to improve outreach and enrollment services to eligible women and assure capacity to meet the needs of women in their state. Preconception health is a focus of many MCH programs that work to improve women’s health prior to pregnancy in order to improve pregnancy related outcomes. State MCH programs also fund state-wide smoking cessation or “quit lines” for pregnant women and provide education within their state on the dangers of smoking during pregnancy.

**Continue to build and strengthen partnerships.** Women are served by numerous agencies and organizations at the state and local level. As such, partnerships between the key public and private systems and programs that serve women are essential to maximizing investments and minimizing duplication of effort. State MCH programs have existing partnerships with state and local health agencies, and community-based health and social services agencies – partnerships that will continue to be critical as ACA, particularly those provisions women’s health are implemented.

**Sources and Selected Resources for Further Information**

- **Association of Maternal & Child Health Programs.** Additional information covering key aspects of ACA that pertain to MCH populations is available at: [http://www.amchp.org/Advocacy/health-reform/Pages/default.aspx](http://www.amchp.org/Advocacy/health-reform/Pages/default.aspx)

- **Maternal and Child Health Bureau, Health Resources and Services Administration, HHS.** Information on the Title V Maternal and Child Health Services Block Grant and other related programs and efforts is available at: [http://www.mchb.hrsa.gov/](http://www.mchb.hrsa.gov/)

- **Health Reform for American Women** [www.whitehouse.gov/healthreform](http://www.whitehouse.gov/healthreform)


**AMCHP Staff Contact Information**

This fact sheet is part of a series of AMCHP tools, documents and resources on implementation of the ACA and its impact on maternal and child health populations. For more information, please visit the AMCHP website at: [amchp.org](http://amchp.org) and/or contact the AMCHP staff listed below. All AMCHP staff can be reached by phone at: (202) 775-0436.

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