

ACOG's Health Care Reform FAQs for Women

Will my insurance company be required to cover maternity benefits?

All plans sold through newly established State Health Insurance Exchanges must cover maternity and newborn care benefits beginning January 1st, 2014. However, plans that were in existence before March 23, 2010 when this law was enacted (grandfather plans) are exempt from this benefit requirement.

What other benefits are insurance companies required to cover?

Beginning January 1st, 2014, all plans sold in the State Exchanges and all individual and small group market plans sold outside the Exchanges (except grandfathered) are required to offer at least the essential benefits package which includes: maternity and newborn care benefits; ambulatory patient services; emergency services; hospitalization; 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.

Is there another plan I can buy if I don't want all those benefits?

Catastrophic plans will be available to individuals under age 30 who want to purchase a higher deductible plan through the State Health Insurance Exchange and individual and small group markets. These plans must cover catastrophic care benefits, but are not required to include the essential benefits package, including maternity care.

Can my insurance company deny me coverage if I'm pregnant?

Not after January 1st, 2014, when the law prohibits insurance plans from denying women coverage on the basis of pregnancy, previous c-section, domestic violence or other medical conditions. Group plans in existence before enactment of this law must comply, but individual market plans in existence before enactment of this law are exempt.

What other insurance reforms and requirements affect women?

- **Direct Access** – You are guaranteed direct access to your ob-gyn, without having to get a referral from your insurance company. Your insurer cannot limit your access to your ob-gyn to a certain number or types of visits.
- **Fair Insurance Rating** – Beginning in 2014, all insurance plans in the individual and small group market will no longer be allowed to charge women higher premiums for the same insurance plans as men. However, rates may vary by family size, geographic area, age (by no more than a 3:1 ratio), and tobacco use (by no more than a 1.5:1 ratio).
- **Abortion** – These details apply only to insurance policies offered in the new State Health Insurance Exchanges, beginning in 2014. Abortion coverage is not required to be part of a

minimum benefits package, and no federal funds or tax credits may be used to pay for abortions, except for abortions in case of rape, incest, and when the pregnancy puts the mother's life in danger. Anyone who purchases a health plan with abortion coverage beyond those three cases through a State Health Insurance Exchange has to make two separate premium payments: one for abortion coverage and one for the rest of the coverage. States can ban plans in the Exchange from offering abortion coverage beyond ones in cases involving rape, incest, or life endangerment of the mother.

Does everyone have to be insured?

Beginning in 2014, U.S. citizens and legal residents will be required to have qualifying health coverage, or pay a tax penalty. The penalty will be phased in beginning with \$95 in 2014 and \$325 in 2015. In 2016 the full penalty kicks in, the greater of \$695 per year up to a maximum of three times that per family (\$2,085) or 2.5% of household income.

What financial assistance does the law provide?

- States can contract with health plans to cover individuals and families who are not eligible for Medicaid based on income requirements, or other coverage, and have income below 200% of the federal poverty level (\$21,660 for an individual and \$44,100 for a family of four in 2010).
- Beginning in 2014, tax credits for premiums will be available to help individuals and families purchase insurance through the State Health Insurance Exchange, if they have income between 100% and 400% of the federal poverty level (between \$22,050 and \$88,000 for a family of four in 2010) and are not eligible for other coverage.

How does the law affect Medicaid?

- If you get your health care coverage through Medicaid, you won't lose any benefits.
- Starting October 1st, 2010, Medicaid must cover tobacco cessation services for pregnant women (including diagnostics, therapy, and counseling services).
- Beginning on January 1st, 2014, all individuals and families with incomes up to 133% of the federal poverty level (below \$29,327 for a family of four in 2010) can enroll in Medicaid, and must be guaranteed an essential benefits package.
- States have the option to cover family planning services for non-pregnant women with incomes up to the same level at which Medicaid in your state covers pregnant women currently. States can only count your income, not the income of your parents, partner, or spouse with whom you're living when determining if you are eligible for this benefit. Visit www.kff.org/medicaid for more information on Medicaid eligibility in your state.
- If you are on Medicaid and have 2 chronic conditions, or have 1 and are at risk for a second, Medicaid may require you to choose a medical practice as your "medical home." That practice will be responsible for coordinating your care and facilitating your access to a range of comprehensive care services, and ob-gyn practices are eligible to serve as your medical home.

What insurance protections begin this year?

- Dependent children up to age 26 can go on their parents' health plan.
- People with pre-existing conditions, who have been denied coverage by a private health insurance plan for at least 6 months, will be eligible for a high-risk health insurance program through your state.
- Insurance plans cannot set lifetime caps on coverage and cannot cancel your policy when you get sick.

- Health plans cannot deny coverage to children with pre-existing conditions.
- All plans must cover mammography, immunizations recommended by CDC, and women's health preventive services, with no co-pays or deductibles for you.

What other pregnancy related provisions are in the law?

- **Pregnancy Assistance for Students** – Beginning in 2010, \$25 million will be granted to high schools, colleges, and universities for pregnancy assistance for students, to improve access to community resources, pay for maternity care in student health plans, help pay for family housing, child care, maternity and baby clothing and other items to assist parents, and pay for post-partum counseling. Funds may also be used to pay for intervention and counseling services for victims of domestic violence
- **Breast Feeding** – If you work, your employer is required to provide break time for you to express breast milk for 1 year after your child's birth and provide a place that is shielded from view and free from intrusion. Your employer does not have to pay for this break time, and businesses with fewer than 50 employees are exempt if it would cause a hardship for them.
- **Maternal and Newborn Home Visitation** – Beginning in 2010, states can develop a home visitation program to improve maternal, infant, and child health, especially in areas with high infant mortality, poverty, substance abuse, and crime. Home visitation programs must provide information and services to families to improve maternal and newborn health, school readiness, and family economic self-sufficiency, prevent child injury and abuse, and reduce crime.
- **Post-Partum Depression Services** – Non-profit hospitals, community health centers, and other community-based organizations will develop treatment, support services, and education and outreach programs to women at risk for post-partum depression. Soon you'll see television and radio public service announcements to raise awareness about post-partum depression and encourage women to seek treatment.

What other women's health provisions are in the law?

A national campaign will **increase awareness among young women on good breast health**, risk factors for breast cancer, and early detection, and provide information to women who have been diagnosed with breast cancer.

What programs in the law provide sex education?

- **Personal Responsibility Education** - \$75 million will be allocated among the states each year from 2010 to 2014 to implement personal responsibility programs to reduce pregnancy rates in youths. Educational programs must include abstinence, contraception, and STD and HIV prevention, and three or more adult preparation subjects: parent-child communication, adolescent development, financial literacy, education and career success, healthy relationships, or healthy life skills.
- **Abstinence-Only Education** – \$50 million per year will be divided among the states for abstinence-only education through 2014.

Does the law help me choose good doctors?

Possibly. A new national Physician Compare Website will allow you to compare your doctor's quality of care and patient satisfaction to other doctors, beginning on January 1st, 2013.

How does the law affect illegal immigrants?

Illegal immigrants are not eligible for any of the provisions in this law. They are not allowed to purchase insurance through the State Health Insurance Exchanges, even if they purchase it with their own money.

Are legal immigrants eligible for any provisions in the law?

Yes. Legal immigrants are eligible to purchase insurance in the State Health Insurance Exchanges without waiting periods, and those with pre-existing conditions are eligible for the “high-risk” pools that will be set up in the states. They must comply with the individual mandate to have qualifying health insurance by January 1st, 2014. Legal immigrants whose income is below 133% of the federal poverty level (\$29,327 for a family of four in 2010) and who are not eligible for Medicaid based on the five year waiting period are eligible for state contracted basic health plans. Legal immigrants are eligible for tax credits and cost-sharing reductions, subject to verification requirements.