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Women's Health under the Affordable Care Act
Kaiser Family Foundation
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PENNY DUCKHAM: Thank you and welcome to today's webinar. This is the seventh in our series exclusively for journalists to give you the chance to look in detail at different aspects of the Affordable Care Act and as you know today, we're focusing on women's health issues, the expanded access to coverage and preventive care for women under the ACA and then we'll be looking more specifically at the Supreme Court issues which will, of course, be starting around March the 25th with the upcoming hearing. With that, I just want to remind you that the whole purpose of this is to provide you with the chance to ask questions so feel free to do that by the chat as we're going along and then we will get back to answering them at the end of these presentations by my colleagues, Alina Salganicoff, the Vice President and Director of the Women's Health Policy Program at the Kaiser Foundation, and her colleague, Laurie Sobel, Senior Policy Analyst.

I'm going to hand over straight to them because we've got quite a bit to cover today.

ALINA SALGANICOFF, PHD: Great. Thanks so much, Penny. What Laurie and I want to do today with our time is to really provide you with an overview of some of the important changes that have occurred for women's health coverage and access as a result of the Affordable Care Act. I'm going to provide an overview of the major issues for women with a focus on

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eligibility for coverage and enrollment, preventive services, and also other benefits that are important to women including maternity care and mental health. Laurie will then drill down further into the issues in play right now regarding contraceptive coverage and abortion coverage.

Before we move ahead, I do think it's important to recognize that not only were women's groups on both sides of the aisle deeply engaged and up the run up to ACA but other groups and constituencies have also focused on the women's angle during the debates. Many women felt that they had much at stake and many women's organizations have also been very engaged in the early stages of implementation. Why is this?

Well, we know that women have a relationship with the health care system that's different than that of men, their reproductive needs, their role as a family caregiver for parents, kids and spouse, and the fact that they live longer with more chronic illness require that they interact with the health system at higher rates than men. In addition, a higher share of women than men are low income and as a result, they are more sensitive to cost as it affects health. This data is from the monthly *Kaiser Health Tracking Poll* and you can see here on every indicator, women, shown here in orange, report cost-related barriers to care at a higher rate than men, ranging from postponing or skipping care to taking medications to getting mental health care.

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One of the problems that the ACA was designed to address was the lack of access to affordable coverage that was experienced by millions of Americans. Before the coverage expansion took effect in January, nearly one in five adult women, that's 18.7 million women in the United States, was uninsured. This is shown in the orange slice of the pie. It is anticipated that the majority of uninsured women will qualify for either Medicaid, tax credits to help with the cost of insurance, or be able to gain access to coverage through the state Marketplace. That's regardless now of health status. Early enrollment data show that women comprise 54-percent of the new Marketplace enrollees despite having lower uninsurance rates than men. This highlights the value that many women place on coverage. However, many women, nearly 5 million of them, are not eligible for assistance. About 2.5 million uninsured women shown here in the gray bar on the right column are undocumented. These women are banned from receiving any assistance under the law. Another 2.4 million women are poor and in the coverage gap. This is because they reside in one of the 26 states that have decided not to expand Medicaid eligibility at this time. These states are shown here in orange and light blue.

The ACA provides states with federal funding to expand Medicaid to all persons with incomes below 138-percent of the federal poverty level regardless of family status. The Supreme

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Court ruling, however, essentially gave states the option whether or not to expand Medicaid. As a result, about half of the states have chosen to keep eligibility rules at pre-ACA level. What this means is that poor women and men living in these states who are currently uninsured will not have access to affordable coverage because they don't qualify for Medicaid and are too poor to qualify for tax credits to enable them to afford coverage on the exchange Marketplace.

In addition to the coverage expansions, the ACA includes many reforms such as access to insurance and the scope of coverage for women. Before the passage of the Affordable Care Act, parents were typically not allowed to keep their adult dependent children on their plan. It was perfectly legal for plans also to apply pre-existing condition limitations on coverage. This included women who were pregnant or those who had a history of domestic violence or depression in addition to a history of other medical conditions, and these individually purchased plans rarely covered maternity care or charged women for expensive riders to cover maternity care. Today, adult children can stay on their parents' plans until they turn 26 and we've seen a reduction in the uninsurance rate in this age group by 5-percentage point in just three years. Furthermore, pre-existing condition exclusions and gender rating are banned, and all plans must cover maternity care. Another major change

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has been the requirement that new plans cover preventive services.

The reason that this is so important is that, for the first time, there is a federal requirement that plans cover preventive services. In the past, there was just a patchwork of state rules so that the extent of benefits that you received depended on where you lived and the type of plan that you were enrolled in. Each rule now applies to all new private plans. This includes those that are self-insured sometimes known as self-funded or ERISA plans, individual plans that are privately insured, as well as small and large group plans. Plans that are grandfathered, that is, they didn't change substantially since March 2010 are exempt but it's anticipated that over time, most plans are going to lose their grandfather status and will provide these benefits. This benefit is also a requirement for the plans that are going to be available in the state Marketplaces.

I put this slide here to illustrate that this is a very large list of services. For adults, they include all the US Preventive Services Task Force recommended services, all immunizations recommended by the CDC's Advisory Committee on immunization practices, and eight new benefits noted here in red that were recommended by an IOM Committee of women's health experts. These new services include the contraceptive coverage that's in the center of so much attention but also

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breastfeeding support, intimate partner violence screening, and well-women visits. Clearly, an important issue to follow will be how insurance plans will implement this new rule as they are still permitted to use medical management rules to determine how they will cover these services.

While there's been lots of attention to these new benefits particularly the contraceptive coverage rule, the evidence is clear, however, that having coverage does make a difference when it comes to getting preventive services and that cost sharing can be a barrier to getting care for those who are insured. This data that we just collected in the late fall from the *2013 Kaiser Women's Health Survey*, this is a sneak preview of some more new data that we will be releasing soon, and it shows that women with coverage get preventive services at higher rates than noninsured women shown here in orange. It is worth noting, however, that utilization rates for many services are still below the goals that are set by the CDC's Healthy People 2020 Target.

Another issue that is very important for many women at some point in their lives and I would say to men as well as fathers is maternity care. Notably, pregnancy can no longer be considered a pre-existing condition as it was in the past, and maternity care and newborn care are included as one of the essential benefits that all plans must now cover. Maternity care was historically excluded for most individually purchased

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plans. Prenatal visits and recommended screening including breastfeeding support including lactation consulting and the cost of breast pump rental are now covered without cost sharing. That is free of cost. The law also made some changes to Medicaid which currently funds nearly half of all births in the United States. This includes mandatory coverage of tobacco cessation which was unevenly covered across the state as well as coverage for all newborns that lack any other form of coverage. In addition, an issue that hasn't gotten much attention is the new workplace protections for nursing moms which requires employers with 50 or more workers provide women with adequate break time and a private place to express milk that is not a bathroom.

I also briefly wanted to touch on mental health issues which are also critically important for women. Women and men differ in terms of how they experience mental health problems. As you can see here in the orange, anxiety, depression, PTSD and panic disorders are experienced by women at nearly double the rates of men. Clearly, access to affordable coverage will help millions of women who have been uninsured obtain needed medical care and because mental health is now an essential health benefit, it means that women who gain coverage on the exchange in a non-grandfathered individual plan will have mental health benefits on par with what they get with medical services. In the past, only 18-percent of individual policies

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even covered mental health care and now, women can use these services without fears that it will be counted as a pre-existing condition should they need to secure coverage in the future. This was a legitimate concern for many in the past.

Finally, I wanted to touch on the Medicare issue. This has gotten much less attention. Medicare also under Part B extends coverage to the US Preventive Services Task Force recommendations as well as the yearly wellness visit. This is really important because half of women on Medicare live on incomes under \$20,000 a year so the fact that they can have first-dollar coverage for preventive services is very important to these women.

Now, I want to turn it over to Laurie who's going to really focus now on the coverage of contraception and abortion coverage.

LAURIE SOBEL: Hello, everybody. This is Laurie Sobel. As part of preventive services under the ACA, all new private plans must cover the full range of FDA-approved contraceptive methods as prescribed at no cost to the consumer. This includes doctor's visits for counseling, insertion, removal, and follow-up. There are some exemptions and accommodations for some nonprofits that I will talk about in detail in a few minutes.

As you can see in this slide, there is a wide range in cost for FDA-approved contraceptive methods. Keep in mind, a

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woman's reproductive lifespan is approximately 30 years. Women who could not previously afford contraceptive can now access the full range including reliable, long-acting, reversible contraceptives like IUDs.

There have been a lot of controversy and confusion about which employers are required to cover contraceptive. I'm going to walk you through this slide explaining the exemptions and accommodations.

Starting at the left, we have nonprofit houses of worship. These are churches, mosques, and synagogues. These employers are exempt. The employer is not required to offer contraceptives but they can if they have no religious objections. The employees of these employers that are houses of worship and their dependents do not have guaranteed coverage to contraceptive.

Moving to the right in the middle in the dark blue, we have all for-profit employers. All for-profit employers must include contraceptive coverage. There are no exemptions or accommodations for for-profits.

Now, on the far right in the light blue, we have nonprofit employers that falls in two categories. There are secular nonprofit employers that are required to provide contraceptive coverage. Then, onto the further right, we have the religiously affiliated nonprofit employers like Notre Dame University or Catholic hospitals. These employers can get an

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accommodation if they self-certify that they object to providing contraceptive coverage based on religious grounds and provide a copy of this self-certification to their insurer or if they're self-insured to their third party administrator. This removes the burden of paying for the contraceptive coverage from the employer to the insurer or third party administrator. The employees and the dependents of these religiously affiliated nonprofits will receive the contraceptive coverage. They will just receive it directly from the insurer or the third party administrator.

More than 90 lawsuits have been filed by nonprofits and for-profits challenging the contraceptive coverage requirement. I'm going to focus on the two cases brought by for-profit employers which will be heard by the Supreme Court in March. The two cases are Hobby Lobby and Conestoga Wood Specialties. Both are for-profits, privately held companies. Hobby Lobby is a national chain of craft stores with over 13,000 employees. The owners are the Green family who are Protestants and object to providing health insurance for IUDs and emergency contraceptives including Ella and Plan B. Conestoga Wood Specialties is the wood cabinet manufacturer and has 950 employees. The owners, the Hahn family, are Mennonites and object to providing insurance coverage for Plan B and Ella. Both owners and companies are contending that the contraceptive

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coverage requirements as applied to them violate the First Amendment and the Religious Freedom Restoration Act.

At the heart of this litigation is the Religious Freedom Restoration Act. Congress passed this Act in 1993. The act states that the government shall not substantially burden a person's exercise of religion unless that burden is the least restrictive means to further a compelling governmental interest.

Let's break down RFRA, the Religious Freedom Restoration Act, to understand what the Supreme Court must consider in these cases. You see on this slide, there is a series of questions and depending on the answer, the court will either stop because there is no violation or move along to the next question. The first inquiry on the far left is whether the employer is a person that can exercise religion. This is the first time the Supreme Court will be considering this question, whether a for-profit can exercise religion. If the court answers this question yes, this will open a big door for for-profit companies asking for exemptions from other laws. Next, the court will move on to the second question. Does the requirement to provide health insurance for contraceptives substantially burden the employer? If the answer is yes, then we move to the third question. Does the government have a compelling interest to provide health insurance coverage for contraceptive? If the answer is no, then the law violates

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RFRA. If the answer is yes, we move on to the last question. Is this the least restrictive means of meeting this compelling interest? If the answer is no, then there is a violation of RFRA. If the answer is yes, then there is no RFRA violation.

As I just mentioned, the Supreme Court's decision on these cases could have very far-reaching consequences. If the court holds that for-profit corporations can exercise religion, some employers may contend they have religious objections to various aspects of health care including blood transfusions, vaccinations, infertility treatments, psychiatry treatment and drug, and health insurance all together. Beyond health care, employers could ask to opt out, that the civil rights law was meant to protect people from employment and housing discrimination based on race, gender, religion, national origin, or pregnancy.

I'm going to shift now to talk about insurance coverage for abortion. At the federal level, the ACA explicitly banned abortion as being included as an essential health benefit. State policy also shapes coverage for abortion under Medicaid, state Marketplaces, and private insurance. Under Medicaid, the Hyde Amendment limits the use of federal funds to abortion coverage only in the cases of rape, incest and life endangerment. 33 states in D.C. limit abortion coverage of Medicaid to these circumstances. States can also prohibit plans in the state Marketplace to include abortion coverage and

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24 states so far have done so. Nine states have banned or restricted abortion coverage in plans sold outside the Marketplace by private insurers in their state.

Looking at this map, we see the availability of abortion coverage throughout the country. The nine dark orange states are the states that I just mentioned that have restricted abortion coverage in Medicaid, the Marketplace as well as private insurance sold in their states. The dark blue states are where there are no restrictions on abortion coverage. The light orange and yellow states are in the middle with one or two restrictions on abortion coverage in the insurance plans, Medicaid and the Marketplace.

This pie chart shows the availability of coverage for previously uninsured women ages 19 to 49 who are now eligible for coverage. As you can see with the dark blue, just over half of these women are eligible for coverage that includes abortion without restrictions. Just over one-third or 3.9 million women only have coverage options with restriction on abortion coverage, and 15-percent, 1.8 million poor women, fall in the coverage gap but 99percent of these women live in states that restrict abortion coverage under Medicaid so even if their state expanded Medicaid, these women would still only have coverage with the restrictions on abortion coverage.

In summing up, here are some things to look for. Enrollment is clearly the number one priority for the

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administration, and women comprise a little more than half of early enrollees but there are still 2.4 million poor women in the coverage gap with no access to affordable coverage. Under the ACA in addition to broadening coverage for maternity care and mental health, there is now a wide array of preventive services that are covered with no copay. These are important big changes. The continuing monitoring is necessary to enforce the no-cost preventive services for women and determine if there are still gaps. For reproductive services, there is still a lot in play. The Supreme Court's oral argument for Hobby Lobby and Conestoga Wood Specialties is on March 25th, and a decision is expected in June. Abortion coverage rules are still in play at the federal and state levels.

We'll stop there and I'll turn it back to Penny to facilitate the questions.

PENNY DUCKHAM: Thank you. Just a couple of points which I've forgot to cover at the beginning which is one that we will post an audio version of this webinar on our website probably by the end of today and shortly after that, we will have a transcript available for those of you who might want to have that. On a more substantive note, as we said in the beginning, please send in your questions by the chat function at any point now and we will start answering that but on a more substantive note, before we go any further, could you just go

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back over. We've had a question about Ella and Plan B, both mentioned as part of the Supreme Court March the 25th case.

ALINA SALGANICOFF, PHD: Ella and Plan B are both oral emergency contraceptives. Plan B is available over the counter and Ella is a prescription medication that also is an emergency contraceptive. Ella, you need a prescription. Plan B is available over the counter.

PENNY DUCKHAM: Another clarification to questions. I'm sorry if there seems to be some mismatch between the slides coming up and the presentation. I don't know why that's happening but all slides will be available shortly after the end of this webinar so you'll certainly have those. If you'd like us to go back over any of them now, here's your chance to chat but otherwise, we are here and welcome any questions you may have. Please feel free to send them our way.

We can start now with the questions from Martel Eunice [misspelled?]. What is the likely effect of a ruling against the administration in the Hobby Lobby case?

LAURIE SOBEL: This is Laurie Sobel. It depends on exactly how the court rules and how broad it is. If they rule that the for-profit companies do not have to provide contraceptives based on religious grounds, then we can foresee that many other for-profit companies might come forward. There are already 46 for-profits that have sued on grounds that they have religious objections to providing the contraceptive

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coverage. It's not obviously as big a case as the ACA challenge altogether but it could have significant effect on the availability of contraceptive coverage through employers.

PENNY DUCKHAM: On the follow-up from that, Jane Amari [misspelled?] has asked, Hobby Lobby says it only objects to abortions and using contraceptives and clearly [inaudible] but do you see a way for the courts to accept these arguments and possibly define two categories of contraceptives?

LAURIE SOBEL: Well, this is Laurie again. The FDA has categorized both of those drugs as contraceptives and based upon scientific evidence, they've made that determination so I would think it would be highly unlikely that the court would then go around and try to overrule the FDA determination of the category of those drugs.

ALINA SALGANICOFF, PHD: Yes. This is Alina Salganicoff. There have been other scientific bodies who have also reviewed the literature and find that these emergency contraceptives actually do not disrupt an implanted pregnancy.

PENNY DUCKHAM: We are going to go back now to the pie chart slide. I think there's only one of them.

LAURIE SOBEL: There are two.

PENNY DUCKHAM: There are two so I'm not quite sure. John Barrett, if you want to just clarify which one you were going for or we can go over both of them. We will start by going over the one about abortion coverage for women uninsured.

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LAURIE SOBEL: Sure. What we're looking at here is availability of coverage for newly insured women ages 19 to 49. These were women who were previously uninsured, and this is based upon the restrictions that different states have made on abortion coverage. As you see, the dark blue, just over 50-percent of women will have access to coverage without restrictions on abortion. In the dark orange, we have about a third of the women, almost 4 million women who have access to coverage but only with restrictions for abortion coverage and then in the yellow, we have the women that still won't have any available affordable coverage and they fall into the coverage gap.

ALINA SALGANICOFF, PHD: We came to these calculations by actually looking at the policies in each state and then looking at the women who would have been eligible in each of these categories.

PENNY DUCKHAM: Now, we're going to go back to the other pie chart in case that's going back to the beginning of this webinar.

ALINA SALGANICOFF, PHD: What this does is really teases apart how women who are currently uninsured will qualify based on their income and based on the state that they live in and so if you start-starting at the bottom, those are the women, 2.5 million women, who are undocumented, that is, they are banned from receiving any federal assistance either through

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Medicaid and even purchasing coverage on the exchange. There are 2.4 million women who are in the coverage gap. Those are women who live in states that are not expanding Medicaid that are also poor. There are 4.4 million women who are going to be Medicaid eligible. There's another 6.8 million who are going to be eligible for tax credits, that is, their income is between either 100- or 138-percent of the poverty level depending on their state and 400-percent of poverty and so they will receive subsidies in the form of tax credits which will allow them to buy coverage. Then, there's another 2.6 million whose income is too high to qualify for tax credits but they also will qualify for care in the Marketplace if they have a pre-existing condition or any other issue and also will be able to take advantage of the lower rate.

PENNY DUCKHAM: Here's a question from Lorraine Grossman [misspelled?]. How would the challenge from for-profit companies affect the challenge by nonprofit groups like Notre Dame?

LAURIE SOBEL: This is Laurie again. For the nonprofit, I mean you go through the same RFRA analysis but they have a much easier time showing that they have the ability to exercise religion as a nonprofit religiously affiliated organization. The accommodation is different from the nonprofits in that category so the question on the burden is different because essentially what they'll require to do is to

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self-certify that they have religious objections to the contraceptive coverage and provide that certification to either their insurer or third party administrator. The analysis about the burden would be different but the analysis about the compelling interest as well as whether the government is meeting that compelling interest in the most restrictive way will be similar to the for-profit companies.

PENNY DUCKHAM: Here we're shifting slightly to a question from Kathleen Dorney. Can you suggest any action points or breaks for women trying to get coverage or women new to coverage? That's a pretty broad question but accessing [interposing].

ALINA SALGANICOFF, PHD: This is a great question because I think what we're trying to do is not only reach women who have had coverage in the past but there are a lot of women who have had no experience and so a lot of those women are going to be eligible —there are groups that are working with them. I think women can reach out to their clinics that they had been seeing. I know that a lot of the family planning clinics have people that are trained to help women enroll as well as community health clinics. In addition to that, the state websites and the federal websites are supposed to be working better but there are a lot people who need to enroll. The nonprofit groups had navigators as well that are trained to help women and individuals enroll.

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PENNY DUCKHAM: [Inaudible] asks can you explain how patients cared for in free primary care clinics might be affected? I think that is generally by under the ACA but also touched specifically as regards.

ALINA SALGANICOFF, PHD: Well, really again it depends on your categorization. The primary care clinics, the free clinics like community health centers and other family planning clinics are going to continue to be there. There's still going to be a tremendous need to have these clinics because as I mentioned earlier, there are 5 million women who are not going to be eligible for services but that are currently eligible for coverage and are currently residing in the United States but in addition to that, a lot of women now who are using these clinics are now going to be eligible for coverage either Medicaid or subsidized coverage through the exchange. I think it is important for those women to contact their clinics if they want to continue that relationship, to try to find out which of the plans their clinics are participating in so they can continue to have seamless coverage and make sure that that network includes their clinic.

PENNY DUCKHAM: Just to be clear, that was Alina Salganicoff. We didn't identify her. Now, a question from Suzanne Jacques. You mentioned those concerns about the implementation of free preventive health benefits. Can you give some examples of access problems?

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LAURIE SOBEL: This is Laurie. For the contraceptive coverage, there is under the guidelines, plans are allowed to use reasonable medical management to implement that provision and so what that generally means is that they can require women to obtain the generic birth control pill rather than a brand name birth control pill but we don't know what other provisions plans are going to be using in terms of cueing or putting up barriers to some of the more expensive contraceptive coverage for women so that's what we need to have continuing monitoring around that implementation.

ALINA SALGANICOFF, PHD: Yes. I think even if you've looked even beyond contraceptive coverage, if you look at, for example, the breastfeeding support, who are the providers who are going to be actually qualified to provide the education, consultation, what types of breast pumps are going to be available, around the intimate partner violence, how is that screening going to be done, and how are the referrals going to be handled. The evidence is there that screening and referral and counseling does make a difference in terms of reducing harm for women who are experiencing intimate partner violence but this is a new issue for both health care providers and insurers to cover now and so I think that there is going to be a large learning curve.

PENNY DUCKHAM: Now, Chandra Wright is coming to ask has the Establishment Clause come into the Hobby Lobby case at

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all. There was an editorial piece in *The New York Times* today but Laurie [interposing]—

LAURIE SOBEL: The Establishment Clause just to remind everybody of your Legal 101 is basically that the government and the church need to be separate and that one cannot impose the religion on somebody else and so this wasn't briefed very much in the government's case - this was just dropped as a footnote Marci Hamilton, a Professor at Cardozo School of Law, has written an amicus brief, writing at length about this and *The New York Times* today just had an editorial suggesting that the court asks for a briefing on this issue specifically. In addition, just in case folks don't know, in the Notre Dame lawsuit, the students have intervened as a party anonymously but represented by counsel as a party in that case basically saying that they have a stake in the case because they as students will do not have access to contraceptive coverage and if Notre Dame is allowed to not provide it and the accommodation is considered to be a burden on them. There's been more and more talk about how this affects both the students in the university setting as well as employees in the employment setting.

PENNY DUCKHAM: Now, we're getting to the crystal ball gazing questions and I'm not sure how capable or willing each one of them but here we go. Mary Silver asks what do you predict about or say commenting about states accepting the

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Medicaid expansion. Alina, do you want to take a crack at that one?

ALINA SALGANICOFF, PHD: Yes. Well, I mean that there that there has been some kind of interest in some of the states—can we go back to the Medicaid map please—in some of the states in looking at alternative to the Medicaid expansion in Indiana and Pennsylvania, for example, so that there are some states that are kind of looking at slightly different ways that they can cover this population, at least through the private sector but in addition to that, I think it is also important to have some historical perspective in terms of just Medicaid implementation over time. Medicaid was not a required program, the states could participate. They didn't all participate initially when the program was enacted in 1965 and in fact, I think Arizona was the last state to join Medicaid in the 1980s. I think that over time, we will see more and more states particularly I think as people realize that there is an inequity there, that you'll have people that are the poorest in the state without a pathway to either Medicaid or access to subsidies because of the way the law is written and people who have slightly higher income will be eligible to get tax credits. So I think over time, we will see more and more states expanding coverage. I think also the safety net providers, the hospitals also will push for these changes, as they have been.

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PENNY DUCKHAM: Marcel Marciellius (?) asks what will be likely the effects of the ruling against the administration in the Hobby Lobby case?

LAURIE SOBEL: Beyond the case itself, any ruling that would rule in favor of for-profits having religious rights would have much broader ramifications. Again, this is the first time the court is looking at this issue of whether a for-profit company can exercise religion and a lot of people point to Citizens United and that was a Free Speech case. This is different. This is about the ability to exercise religion. In the health care context, it really could—you could see a new wave of employers that basically contend that parts of the health care law or parts of providing health insurance conflicts with their religious belief and they want to opt out of those provisions. Beyond that, this case really has very far-reaching consequences in terms of civil rights because employers could basically contend that the civil rights laws violate their religion and that they don't believe that unwed people should live together so they're not going to hire people who are living together that are not married. You can go from there and you can imagine the very large consequences that this could have. Just to keep in mind, there are many amicus briefs that have been filed in the Hobby Lobby and Conestoga Wood. I think at last count, it was 81 amicus briefs, and there're lots of businesses that are submitting amicus briefs in support of

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the government in these cases because they see this as a threat to the corporate structure and that they then might be liable in a different way than before if suddenly corporations could have religious rights.

PENNY DUCKHAM: Anna-Catherine Brigida asks Alina.

Alina, you spoke briefly about the change in coverage for women who experience domestic violence. And under the ACA, what additional services will be covered under the ACA and can you talk in more depth about the implications of this change?

ALINA SALGANICOFF, PHD: Sure. This slide, and this is also available in the Kaiser Brief on Women and Health Reform, but I think that it is really important. This is really an important point because I think that a lot of the attention has been focused on the eight new services but these services cancers, screening and prevention. Recently, the US Preventive Services Task Force also said that preventive medication for women who test positive for BRCA will be covered free of cost sharing. In addition, cervical cancer screening, colorectal cancer screening, screening for a wide range of chronic conditions such as cardiovascular health, diabetes, depression as well as osteoporosis and obesity, all of the vaccines for women and now men, the HPV vaccine has been initially the vaccine that was very expensive and there were some issues there. Now, these are all covered without cost sharing. In addition, counseling and screening around the wide range of

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healthy behaviors and lifestyle, everything from looking at alcohol misuse and overuse, diet counseling, and tobacco cessation as well as now the IPV that I mentioned. In addition, there's a lot there for pregnant women and I think that's really important. We know that part of the big push for the Medicaid expansion for pregnant women was to get women in earlier. The screening and detection services are now covered and with our ability to do many more interventions is critically important to make sure that we have healthy moms and healthy babies. In addition to that, now we have a wide range of reproductive and sexual health screening and counseling that is now covered. A lot of the really important preventive services and by that, I mean screening, early detection and conditions which really are amenable to an early intervention which prevent problems in the long run are now available, guaranteed to women to have that coverage.

PENNY DUCKHAM: Gail Harper asks about Medicaid providers. Since providers have an option whether or not they accept Medicaid payments, what happens when Medicaid providers are not available in a particular area for the uninsured or for the newly insured?

ALINA SALGANICOFF, PHD: Hi. This is Alina Salganicoff. You've touched on really I think an important issue which is that Medicaid has historically been a very low payer compared to private insurance and Medicare. There have

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been issues related to provider participation in Medicaid where there are providers who do not participate in the program. Providers have a choice on whether or not they are willing or unwilling. The bigger challenge has usually been around private physicians much less than hospitals, clinics or health centers not accepting Medicaid. Some have raised concerns that there will be insufficient providers that are available. People are going to be enrolling in Medicaid probably in private Medicaid plans. It is hoped that there will be sufficient providers, but I do think that this is an important area that will generate attention. I think at this point, we don't know. We do know that individuals with Medicaid have better access to care but in terms of whether we're going to have a sufficient provider network to see people on time in a reasonable time I think will vary a lot from state to state and community to community.

PENNY DUCKHAM: Of course, it's been an issue before the Affordable Care Act too. Judy Peres asks Alina. I think this is a follow-up clarification to you please. Did you say breast cancer, chemo prevention will be covered without co-pay only for BRCA carriers?

ALINA SALGANICOFF, PHD: Yes. I believe it's for women like BRCA carriers. I mean if you're at high risk and BRCA carriers are a high-risk group, so yes.

PENNY DUCKHAM: Maybe, just go through BRCA.

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ALINA SALGANICOFF, PHD: BRCA is—there are two genetic mutations—I'm sorry. It's two genetic mutations that are related to a higher risk of breast cancer, BRCA1 and BRCA2. Now, there are genetic tests that can detect women who carry these mutations. Those women are at a higher risk for getting breast cancer. Now, there are chemo preventions. There are medications that are available that can reduce women's risk of developing breast cancer. These are medications that in the past have been given to women who have had breast cancer but now are available to women who have not yet had breast cancer but are at high risk.

PENNY DUCKHAM: I think we're more or less covering all the questions here and we're beginning to run out of time. If there are follow-up questions or if we can do a follow-up response more effectively by an e-mail, we certainly will. I think with that we are, unless you have any closing points, I think we will—

ALINA SALGANICOFF, PHD: No. I would say that there—I mean just in general as a closing point, there is clearly a lot of ground to cover here in terms of the women's health issues. I do think that in terms of looking forward and thinking about what types of stories to cover, I think that there is—the contraceptive coverage and the abortion are often discussed. This is Alina Salganicoff. My colleagues here are flagging me saying "who are you." To look at implementation, I

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think the preventive services, questioning whether the promise of the law really being fulfilled in terms of the coverage. Looking at the networks that are there, are those networks adequate—do they have the specialists that women need? Are the maternity care benefits and the mental health benefits really accessible? I think that there are going to be lots of different stories depending on different communities and different women are going to have different experiences, but I think that there is still a lot more to unfold and learn about in terms of women's experiences.

PENNY DUCKHAM: Well, that's raising a question which is worth touching on here from Gail Harper. Do you have a feel for how the ACA will affect charity care in local hospitals? Will that support questions that might have been [interposing]—

ALINA SALGANICOFF, PHD: I think a lot of it will depend on the charity care. There's still going to be a need for local hospitals to provide charity care. The net for the ACA will reach many people and those hospitals who have more insured patients either through Medicaid or through private insurance will have a revenue source, but there will still be significant numbers of people who are uninsured and those hospitals will still be obligated to provide care for those individuals, particularly in cases of emergency care. We will still very much need a very robust health care safety net both in terms of charity hospitals, but also in terms of the vast

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network of community health clinics and family planning providers.

PENNY DUCKHAM: Just as a reminder and there are many resources at Kaiser website, kff.org, we're here to answer questions and just put a plug in for Alina Salganicoff in case it's relevant for you or for your audiences as she is a bilingual Spanish-speaking expert which may be useful to some of you to know. Again, we will have all the slides and the presentations up on our website later today and we will get a transcript as quickly as we can.

In the meantime, thank you very much for your interest and this is Penny Duckham saying thank you very much. As we finish up this webinar, if you have ideas or other issues that would be useful to go into some of that, please let us know.

[END RECORDING]

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