

May 22, 2009

Senator Max Baucus  
511 Hart Senate Office Building  
Washington, DC 20510

Senator Chuck Grassley  
135 Hart Senate Office Building  
Washington, DC 20510

Dear Senators Baucus and Grassley:

As members of the Women and Health Care Coalition—a coalition of leading patient, provider, public health, legal and grassroots organizations committed to protecting and advancing women’s health, we thank you for the opportunity to comment on the Senate Finance Committee’s Policy Options for Expanding Health Care Coverage (“Coverage Policy Options”).

Today, millions of women depend on a health care system that is failing them. They struggle to get necessary health care or go without it altogether. Unequal access to affordable, high-quality health care leads to poorer health outcomes, particularly for women of color, poor women, immigrant women, women who are lesbian, gay, bisexual or transgender (LGBT), women with disabilities, women living in rural communities, and women with both chronic and acute medical conditions.

Women are ready for health reform that addresses their specific health care needs and the challenges they face in getting care. We are especially supportive of those Coverage options which would increase access to affordable health coverage; strengthen public health insurance programs; end insurer practices of denying coverage based on health status or setting premiums or coverage based on health status or gender; provide a public health insurance plan option; emphasize prevention and wellness, and eliminate health disparities. We believe several of these options for reform can be even stronger by ensuring that insurance market reforms apply to the sale of all health insurance; assuring that premium rating factors do not result in unaffordable or unfair premiums; adopting caps on out-of-pocket costs; and, eliminating the range of inequities that women face in the health system. Furthermore, we strongly urge the committee to include a provision that would prohibit discrimination in the implementation of any health care reform legislation.

Our specific comments on the proposed options follow. We look forward to working with you and the members of the Senate Finance Committee to adopt health reform legislation that will ensure that all women have access to the affordable, quality, comprehensive health care they need to lead healthy lives.

## I. Insurance Market Reforms

- **Non-group, micro group and small groups: We support the proposed insurance market reform that would eliminate gender and health status as premium rating factors, and impose guaranteed issue and renewal to the non-group, micro group and small group markets. However, to ensure price fairness in all health insurance, the insurance market reforms should apply to all group coverage – including groups larger than state-defined small groups.**

As proposed, the Insurance Market reform option would apply reformed rating rules to the non-group, micro group, and small group markets; the size of the small group market would be defined by state law. The only permitted rate variations would be based on tobacco use, age, family composition, and geography – with a maximum combined rate variation of 7.5:1. We strongly support the proposals that would eliminate gender rating, health status rating, and impose guaranteed issue and guaranteed renewal in these insurance markets.

However, the rating rules option would not apply to groups larger than a state-defined small group. Currently, most states have an upper size limit of 50 employees for a small group while some are at 35 (LA) or even as low as 25 (AR, ND, TN). Thus, the practical effect of limiting these rate rules to small groups is that employers with as little as 26 employees could still face unaffordable and unfair premiums. Specifically, employers with workforces that are predominantly female, or older, or with more health conditions, could face unlimited health insurance costs. Even employers at 51 employees could face significant challenges finding affordable coverage for their workers. Simply put, to ensure price fairness in all insurance markets, **we strongly urge the Committee to apply all proposed insurance market reforms to all non-group and group coverage – regardless of employer size.**

- **The permitted rate variation of a combined 7.5:1 could present significant affordability challenges. Furthermore, the proposed age band may provide little, if any, premium protections, and could result in increased premiums for older enrollees.**

We have concerns that the permissible rate variations could still present significant affordability challenges for many individuals. There must be robust affordability protections that cover these premium rate variations, to assist those who could still face significant affordability challenges with such a large rate variation.

Furthermore, as proposed, the allowable age rate of 5:1 would provide little meaningful protection, and could potentially result in *increased* premiums for older individuals. For example, a quick check in six states for the different premiums charged to a 21 and 64 year-old woman for the two top-selling individual insurance plans sold revealed that all but one of the twelve examined premiums were *below* the proposed 5:1 standard. Thus, we strongly urge the committee to eliminate or significantly reduce the proposed age band, and actively review its implementation to ensure older enrollees have appropriate affordability protections.

- **Health Insurance Exchange:**

- **Small Employer Participation in the Exchange: The Committee should clarify that small employer groups would be rated as a group when participating as an exchange, rather than rating each individual employee.**

As written, the proposed option to allow small employers to obtain insurance through the exchange is unclear as to how these employer groups would be treated for rating purposes: rated as a group, or rated for each individual employee. To avoid undue financial hardship for individual employees due to permissible rating factors such as age, we urge the Committee to clarify that small groups participating in the exchange will be rated as groups, rather than rating each individual employee in a participating small group.

- **Establishment of Multiple Exchanges: Allowing multiple exchanges to compete in a state would create challenges for consumers trying to compare multiple health plan options, and would undermine the benefit of creating larger pools of people to insure.**

One proposed option would allow the establishment of multiple exchanges- such that there could be as many as four competing exchanges operating in a single area. It is unclear what, if any benefit, could be derived from competing exchanges, especially if health plans could not, as stated in the option, selectively participate in one of the multiple exchanges. Having multiple exchanges would only serve to create confusion for consumers trying to choose a plan that is right for them, as well as undermine any potential benefit of creating a large pool of people to insure – and thus spread risk more broadly, ultimately jeopardizing any cost savings benefits of a larger risk pool.

- **Exchange-participating insurance plans should have adequate provider networks that include essential community providers.**

To assure continuity of care and access to necessary health care services in all communities, we urge active oversight of health insurance plans to ensure adequate provider networks and provider participation. In addition, we strongly support a requirement for all health plans participating in the Exchange to contract with essential community providers, such as public hospitals, community health centers, and family planning clinics (similar to the provision mentioned in Approach #3 of the proposed options for Medicaid coverage).

- **Transition: While we recognize the need for phase-in of new rating rules, allowing a phase-in period as long as 10 years for the small group market is too long.**

As proposed, one option would allow states to phase in rating rules for the small group market for as long as three to ten years. Additional proposed health reform options, however, have a much earlier implementation date. While we recognize the policy arguments that would allow the phase-in of these requirements, to allow such a long time to phase in these changes could

create huge inequities during the transition period. Given the inter-connected nature of many of these proposed policy changes, there should be a uniform phase-in period to the maximum practical extent possible.

- **Role of State Insurance Commissioners - Rating Areas: There must be specific protections to ensure that geographic areas as defined by state insurance commissioners are not drawn in discriminatory ways.**

As proposed, geographic rating areas would be defined by state insurance commissioners. If this option is adopted, protections must be included to ensure that these geographic areas are not set in discriminatory ways – based on factors such as income, race, age or gender.

## II. Making Coverage Affordable

- **Benefit Options**
  - **Covered benefits: We support the establishment of a minimum benefit package, and strongly encourage the Committee to adopt a mechanism through which a panel of experts, consumer advocates and other key stakeholders determine the details of the required benefit package.**

We are pleased that the Committee is proposing an option to require all health insurance plans in the non-group and small group market to provide, at a minimum, a broad range of medical benefits, including preventive and primary care, emergency services, hospitalization, physician services, outpatient services, maternity and newborn care, medical and surgical care, prescription drugs, mental and substance abuse services, and others. We strongly encourage the Committee to develop a mechanism through which a panel of medical experts, consumer advocates, and other key stakeholders determine the details of these requirements. To allow this panel to determine these details, we urge the committee to reject legislative efforts to exclude any health care service, such as abortion, from the covered benefit package.

Furthermore, the proposed option indicates that covered benefits would “at least meet minimum standards set by federal and state laws.” Existing federal and state laws include insurance benefit mandates. These laws provide important assurances and protections for women and their families by ensuring that health insurance covers vital health care services and procedures that women depend on. Many of these laws were adopted to remedy insurance company practices that denied or improperly limited coverage. One such example are so-called “drive-through-delivery” laws, which were adopted to address the insurance practice of limiting hospital stays for labor and delivery, ultimately leading to women being sent home too soon after giving birth. We applaud the inclusion of the requirement that covered benefits meet minimum standards as set by federal and state laws – and strongly support its adoption.

- **The four tier benefit options: To avoid underinsured individuals, we recommend elimination of the fourth “lowest” tier benefit option.**

The Coverage Policy Options include the establishment of a Health Insurance Exchange (the “Exchange”) where all participating health plans would be required to offer four tiers of health benefits. Benefit packages in each tier would be required to meet the federally-established minimum benefit standard but would differ in cost-sharing: the percentage of health care costs paid by the plan. Additionally, all Exchange plans would be prohibited from including lifetime or annual limits on covered benefits, and they would also be required to apply cost-sharing parity to certain categories of benefits (e.g. by requiring equitable cost-sharing for inpatient and ambulatory care) and to charge minimal or no cost-sharing for preventive care.

It is commendable that the Coverage Policy Options proposal provides the flexibility to design a selection of benefit packages within an actuarial equivalence framework, while taking steps to ensure that approved health plans cover a comprehensive set of health benefits with limited cost-sharing for preventive care services and without lifetime or annual limits on coverage. We applaud this commitment to comprehensive coverage that emphasizes prevention, does not penalize women and families with greater-than-average health care needs through lifetime or annual restrictions on coverage, and takes significant steps—such as cost-sharing parity requirements and risk-adjustment mechanisms—to prevent insurers from designing benefit packages to encourage enrollment by healthy people (which would contribute to adverse risk selection and threaten the overall health of the Exchange).

However, as currently proposed, insurers participating in the Exchange could design and offer a baffling number of plans within each benefit tier. In addition, given the absence of caps on out-of-pocket costs, the lowest tier option with cost-sharing of approximately 24% could place enrollees at significant financial risk, with plan options that could leave people essentially under-insured.

Accordingly, we strongly urge the Committee to eliminate the fourth “lowest” tier option to simplify the tier options choices and avoid offering coverage that could leave people under-insured. We also urge the Committee to include a mechanism for consumers to easily compare benefit packages in order to choose a plan that best fits their needs. Furthermore, since the proposal relies on methods of actuarial equivalence both to approve Exchange health plan offerings, as well as to determine compliance with potential individual and employer mandates, it is essential that there is ongoing federal oversight to ensure that approved benefit packages are truly comprehensive and remain so over time, and that strong affordability protections are in place to avoid cost-shifting to individuals and families through modifications in benefit design.

- **To prevent financial barriers to care, any deductibles must be prohibited or at least limited, and there must be caps on out-of-pocket costs.**

The structure of cost-sharing from tier to tier, as well as within each tier, could vary tremendously – in ways that could leave consumers at significant financial risk. For example, plans could apply the cost-sharing by using an up-front deductible that could pose financial barriers to necessary medical care. Furthermore, as proposed, any of the tiers could result in unlimited out-of-pocket costs. Ultimately, to avoid cost-related barriers to health care, any

deductibles in these health plans must either be minimal or at best, prohibited, and there must be caps on out-of-pocket costs in all tiers of insurance plans.

- **Cost sharing should be prohibited for preventive services**

In addition, given the evidence that even nominal cost-sharing serves as an access barrier to critical preventive care, the Committee should *prohibit* cost-sharing for preventive services. Finally, any definition of preventive services must include family planning services, which are currently excluded from the US Preventive Services Task Force list.

- **Low income tax credits: Tax credits should be available to assist both with premiums and cost sharing – with caps on all out-of-pocket costs. The value of tax credits must also take into account any premium variation permitted by the new rating rules.**

The low-income tax credit option would apply to premiums and cost sharing. However, the cost-sharing proposal is unclear as to how limits would apply. To ensure affordability, there must be effective caps on all out-of-pocket costs (ie: premiums, deductibles, co-payments and co-insurance) and should apply to all exchange-offered health plans, regardless of whether an individual is eligible for a low-income tax credit. The option should further clarify that the value of the available tax credits would vary so as to provide meaningful assistance to those who face higher premiums due to any of the proposed permissible rating factors (ie: age, family status, geography), up to the maximum proposed 7.5:1.

Finally, the option would use modified adjusted gross income (MAGI) as the measure of income for eligibility. However, adjusted gross income (AGI) would be a preferable income measure, as AGI excludes from income some costs that could be burdensome for low-income people, such as interest on student loans.

- **Small Business Tax Credits: Small business assistance will help women gain employer health coverage; to assure maximum participation, the credit should be simplified, and include non-profits.**

The Small Business Tax Credit option is a positive step that will assist small businesses to provide coverage to their workers. Because women are more likely than men to work for small businesses that do not provide health coverage, providing assistance to these small employers is critical. However, as currently proposed, the credit is complicated; simplification of the credit could help to ensure the highest level of participation.

In addition, as proposed, this option would leave out non-profit entities, as only those entities with tax liability would be eligible. Nonprofits should be permitted to apply the credit against the payroll taxes they pay, otherwise they would not be able to take advantage of the credit. There is precedent for this; the American Resource and Recovery Act COBRA subsidy for employers operates as a credit against payroll taxes.

Furthermore, small businesses should be allowed to carry the credit forward so that it can be applied against profits in future years. This would allow small businesses that would otherwise lose eligibility for the credit if they did not have profits in a given year, to take advantage of it when they have profits and tax liability.

### **III. Public Health Insurance Option**

- **We strongly support the inclusion of a public health insurance option.**

We commend the inclusion of a public health insurance plan option, and strongly support its inclusion in any health reform legislation. The Public Health Insurance option would provide critical competition and choice for consumers purchasing health insurance in the Exchange, and help ensure accountability and transparency in this new insurance market. Many areas of the country lack meaningful competition among health insurers – leaving consumers little or no choice among insurance plans. With administrative efficiency and competition, a public health insurance plan could help drive down costs among all competing health insurance plans operating in the exchange. This will be especially critical during the transition period to new insurance market rules. Of the options presented, we prefer “Approach 1: Medicare-Like Plan.” This would assure maximum efficiencies and use the familiar model of Medicare.

### **IV. Role of Public Programs**

- **Medicaid Coverage**
  - **Eligibility Standards and Methodologies**
    - **We strongly support an expansion of Medicaid that results in a uniform eligibility standard (floor) for families with children.**

Currently, state Medicaid programs have many different eligibility categories, each of which are often associated with different income-eligibility thresholds. This complicated array of eligibility rules results in inequitable access to health care for low-income Americans across the country. We commend the policy option to create a uniform Medicaid eligibility for families with children, which—as proposed—would require a suggested eligibility threshold of 150 % FPL (using a new modified adjusted gross income standard) for pregnant women, children, and parents.

Such a standard would have a considerable coverage impact for low-income women with children, as 44 states currently have eligibility levels for parents and caretakers that are below the proposed level. While eligibility levels for most children and pregnant women are already at or above the proposed standard, these populations would certainly benefit from more uniform eligibility standards in Medicaid, to establish a consistent coverage source for an entire family. This would also help prevent cycling in and out of Medicaid for women. Under the proposed standard, for instance, a low-income pregnant woman would not necessarily lose Medicaid coverage after she gives birth but may instead retain her coverage as a low-income parent.

- **We also strongly support the establishment of a minimum eligibility floor for childless adults, and urge the Committee to adopt this option.**

As currently discussed in the Coverage Options paper, it is unclear how low-income childless adults would be treated with regard to a new national Medicaid eligibility floor. This population is notably absent from the groups to which the proposed Medicaid eligibility standard of 150 % FPL would apply. At one point, the Options paper indicates that childless adults below 115 % FPL would be eligible for federal tax credits to either purchase Exchange coverage or buy into the Medicaid program, but this population is not consistently included as part of a mandatory Medicaid eligibility expansion.

In most states, regardless of how low their income level is, childless adults are not eligible for publicly-sponsored health insurance. Especially when compared to other low-income populations, there is currently a dearth of accessible coverage options for childless adults. It is essential that any uniform expansion of Medicaid also extend coverage to this group. Thus, we urge that health reform legislation extend Medicaid coverage to low-income adults without children to at least 150% FPL, so that this population can benefit equally from important Medicaid protections.

- **States' commitments to their currently eligible Medicaid populations must not expire until it is clear that those beneficiaries have access to other affordable, comprehensive coverage options.**

The Coverage Policy Options indicate that states' responsibilities towards currently-eligible Medicaid populations—which, in most states, extend to pregnant and child populations well beyond the suggested floor of 150% FPL—will expire once the Exchange is fully functioning. This implies that existing Medicaid beneficiaries who do not meet the new Medicaid minimum standards would transition into this marketplace. We are wary of this approach, since it may disrupt care arrangements for vulnerable populations and because it is not apparent that the needs of Medicaid beneficiaries will be met through the Exchange. It is essential that states' commitments to currently-eligible populations do not expire until it is clear that those beneficiaries have access to affordable and sufficiently comprehensive coverage options to meet their needs. In addition, current Medicaid enrollees should have the option to retain their Medicaid coverage to ensure continuity of care. Medicaid includes important affordability protections for low-income people and covers a broad set of services that are essential for women and their families, and states have adopted innovative service delivery models to provide coordinated and integrated care to their Medicaid beneficiaries.

- **We strongly support mandatory minimum provider reimbursement rates under state Medicaid programs.**

Medicaid pays only 60 percent of the overall average provider reimbursement rate for Medicaid, Medicare and commercial plans combined. Lower reimbursement rates have a negative impact on providers' willingness to participate in the Medicaid program, which may leave beneficiaries without reliable access to the care they need. We applaud the Coverage Policy Options proposal

to require a minimum reimbursement level for Medicaid providers (e.g. 80 % of Medicare) as part of a Medicaid expansion, since higher reimbursement rates will have a positive impact on access to care under this critical program.

- **Options for Medicaid Coverage: Regarding the interplay between Medicaid and an Exchange, we strongly support an approach that does not disrupt care arrangements for Medicaid beneficiaries or make it more difficult for them to receive coordinated care.**

The Coverage Policy Options proposes three separate approaches for addressing the interplay between state Medicaid programs and the proposed Health Insurance Exchange—including one option that, because it would require states to shift most Medicaid enrollees into Exchange coverage (potentially with wraparound benefits), represents a major departure from the way Medicaid beneficiaries currently receive their care. The Medicaid program was designed expressly to meet the needs of low-income and vulnerable populations; considering the potential range of benefit packages and health insurers to choose from, it is not apparent that commercial plans operating in the Exchange would be able to fully meet Medicaid beneficiaries' needs for comprehensive and coordinated care—even with the inclusion of wraparound benefits. Therefore, we prefer the first approach, which would keep the Medicaid program intact and enroll all eligible populations (including childless adults) in the program.

- **Other Improvements to Medicaid**
  - **We support reform options that will facilitate enrollment and improve the quality of care for Medicaid beneficiaries.**

The Options paper also includes several proposals that would improve the quality of care provided under Medicaid and that would require states to adopt simplified Medicaid enrollment processes, such as through the elimination of face-to-face interview requirements and assets tests, and the establishment of 12-month continuous eligibility. We support such proposals, as too many women and their families are currently eligible for some type of public coverage program yet are not enrolled. By eliminating complicated and burdensome procedures that provide a disincentive for enrollment, such proposals would make it easier for eligible women and families to apply for and keep public coverage, and overall coverage rates would improve.

- **Family Planning Services and Supplies: We strongly support the Medicaid Family Planning State Option.**

We strongly support the inclusion of the Medicaid Family Planning State Option, a provision that would give states the option of expanding eligibility for family planning services through the Medicaid program, up to the income level at which an individual is eligible for pregnancy services, without having to obtain a section 1115 Medicaid waiver. According to a 2006 study, this provision would provide coverage for family planning services up to an additional three million individuals. Providing such an option would enable states to expand coverage much more quickly, without requiring women to wait on average two years for the state to apply for and obtain approval of a section 1115 waiver, and would give states an additional tool to fill gaps in the health care safety net until coverage is available through other mechanisms.

An alternative approach, building on other coverage expansions being considered by the Committee, would allow states to expand eligibility for family planning services up to either 200% of the federal poverty level or, for states with pregnancy eligibility levels higher than 200% of the federal poverty level, up to the eligibility level at which the state provides coverage for pregnant women. This change would provide states with an even greater ability to expand contraceptive care and other preventive health services to low-income women.

- **Treatment of Selected Optional Benefits: We strongly support the proposal to give free-standing birth centers Medicaid provider status.**

Birth center care is safe, cost-effective, and satisfying for women and families. All women, including those who rely on the Medicaid program for health coverage, should have access to this type of care when choosing a maternity provider. By granting Medicaid provider status, the proposed option would ensure that free-standing birth centers are reimbursed for the care they provide to pregnant women with Medicaid coverage, ultimately strengthening the capacity of these providers to continue serving their communities.

- **Mandatory Coverage for Prescription Drugs: We strongly support the proposal to make prescription drugs a mandatory benefit for categorically and medically needy Medicaid beneficiaries.**

Women use more prescription drugs, on average, than men. This includes greater use of contraceptives and other hormonal medications, drugs to treat mental health problems, and older women's medication needs related to comorbid and chronic diseases. Considering Medicaid's particular importance to women—who comprise 69% of all adult enrollees—a new requirement that state Medicaid programs cover prescription drugs for both categorically and medically needy enrollees would have a positive impact on women's access to health care.

- **Transparency in Medicaid and CHIP: We strongly support efforts to make Section 1115 Waivers and Medicaid State Plan Amendment processes more transparent.**

Publicly-sponsored health insurance programs such as Medicaid and CHIP are especially important to women, who comprise the majority of these programs' adult enrollment. Health reform options that require greater transparency in the processes for developing, implementing, and evaluating state efforts to modify Medicaid and CHIP programs through demonstration waivers and SPAs will promote increased input from critical program stakeholders, including the program enrollees themselves and their advocates.

- **FMAP Automatic Countercyclical Stabilizer: We strongly support a countercyclical FMAP payment formula that would assist states facing increased enrollment during economic downturns.**

Another option would establish a mechanism for an automatic increase in the Medicaid FMAP during periods of national economic downturn, with state eligibility based on average rolling

unemployment rates. The countercyclical nature of the Medicaid program is currently problematic, since the need for public health insurance programs is greatest during times when fiscally-strained states look to those programs to make cost-containing cuts, and the FMAP average from the prior three years does not reflect the current economic picture. We support an automatic FMAP increase, which would ensure that states are able to maintain Medicaid programs and meet the needs of vulnerable populations even as their revenues decline during times of economic recession.

- **FMAP Formula Change: We support the proposed change to the FMAP formula, which would incorporate data on a state's poverty level in addition to data on per capita income.**

The current FMAP formula, which relies solely on a state's per capita income when determining the level of federal reimbursement for its Medicaid expenditures, may not adequately reimburse those states with particularly large gaps between high and low-income populations. A state with a substantial number of both high and low-income individuals may have a high per capita income but also have a large low-income population that qualifies for the Medicaid program—by factoring in two different measures of state poverty, the proposed FMAP formula is more responsive to state needs.

- **Medicare Coverage**
  - **Medicare Disability Waiting Period; Temporary Medicare buy-in: We strongly support both Medicare coverage proposals that would eliminate the disability waiting period, and allow 55-64 year-old adults to buy into the Medicare program; low-income subsidies must be available to assure maximum participation among the most vulnerable.**

The Coverage Policy Options include two commendable policy options: to reduce or eliminate the disability waiting period, and to allow people age 55-64 without ESI or Medicaid coverage to buy in to the Medicare program. We strongly support elimination of the disability waiting period, and allowing an early Medicare buy-in.

The disability waiting period imposes significant hardships on those who need help the most: those who are injured or disabled and need access to medical care. As noted in the Options paper, too many of these Medicare disability applicants are uninsured during the waiting period. Eliminating the waiting period would extend needed health coverage to this vulnerable population.

We also strongly support allowing an early Medicare buy-in program for those 55-64 in age. This type of reform would benefit women in particular, since they are more likely to be married to an older spouse and are at greater risk of losing dependent coverage and becoming uninsured when that spouse becomes eligible for Medicare (and therefore transitions out of job-based health insurance). To ensure that the buy-in option expands access to coverage in an equitable and meaningful way for low-income individuals, the low-income tax credit must also be available to individuals buying into the Medicare program.

## V. Shared Responsibility

- **Personal Responsibility Coverage Requirement:**
  - **Personal responsibility requirements should not take effect until AFTER all insurance market reforms are in place.**

The option for personal responsibility (individual coverage mandate) proposes an effective date of 2013, if not sooner. However, one option would allow a phase-in of the new premium rating for as long as 10 years. No personal responsibility requirements should apply until all insurance market reforms are in place. This would prevent the unfair effect of requiring individuals to purchase coverage with unfair premium rating rules, based on gender or health status, for example.

- **An initial open enrollment period of 45 days is not long enough for such a change; the initial period should be longer. Furthermore, allowing a nine month pre-existing condition exclusion following the initial open enrollment period would be particularly burdensome for women, given the effect on pregnancy.**

One proposed option would provide an initial 45-day open enrollment period; for those who did not enroll during the initial open enrollment period, insurers would be permitted to exclude pre-existing conditions for up to nine months and charge higher premiums. This initial open enrollment period should be longer to give people enough time to fully explore the available coverage options.

Furthermore, a nine-month exclusion would have an obvious disproportionate impact on women, as it would guarantee that pregnancy would be an excluded condition under such circumstances. In addition, there is essentially no other medical condition that would be excluded in its entirety under such an excluded coverage period. If the committee were to consider adopting this option, at a minimum, we strongly recommend an alternative time period for a pre-existing condition exclusion that would not disproportionately and adversely impact women.

- **The proposed excise tax penalty for failure to comply with an individual mandate is regressive and could disproportionately hurt low-income individuals.**

Enforcement of an individual mandate is a difficult proposition. However, as proposed, an excise penalty on an individual would disproportionately hurt lower-income individuals. The penalty for noncompliance with an individual mandate should be more fairly applied, with an income based sliding scale fee schedule.

- **While there should be hardship exemptions from an individual mandate, there should be targeted assistance to ensure that those who truly have no affordable coverage options can obtain health coverage.**

While there should be exemptions from any individual mandate, providing official certification that an individual has no affordable health coverage options does little to help those who clearly need the most help. We would hope that in a reformed health care system, that there would be some special targeted assistance available to those individuals in such a circumstance- where there are no affordable coverage options as defined, where the cost of available health insurance options exceed 10% of income.

- **Employer Requirement: While we support an employer requirement, employers should be required to contribute based on all employees – not just full-time employees – proportional to hours worked.**

We support shared responsibility in a reformed health care system – which includes employers. As proposed, the employer requirement only applies to full-time workers. Thus, employers with predominantly part-time workforces would be essentially exempt from any employer requirement. This could disproportionately hurt women, as they are more likely than men to work part-time, and to be uninsured as part-time workers. Any employer requirement should apply to all workers- with a contribution requirement proportional to hours worked. This will help avoid any incentive for employers to drop hours of work to avoid contribution liability.

#### VI. **Options to Improve Access to Preventive Services and Encourage Healthy Lifestyles**

- **We applaud the options focus on prevention and chronic disease management; however, we urge that cost-sharing be prohibited for preventive care. Furthermore, we urge accountability mechanisms to assure that any workplace wellness programs are not punitive, and allow maximum flexibility for those who juggle multiple obligations outside of their place of employment.**

The Coverage Policy Options include proposals that would encourage the receipt of preventive care by Medicare and Medicaid beneficiaries, such as through a requirement for states to cover comprehensive tobacco cessation for pregnant women with no cost-sharing. The paper also proposes an option to provide grants to states to establish access mechanisms for certain preventive services (e.g. chronic disease management, flu vaccines) for uninsured adults and children until Exchange options are established, funding for states to adopt integrated health and human service delivery systems to promote improved health outcomes, and tax credits for 50 % of costs paid by employer for “qualified wellness program” during the taxable year.

By securing access to timely preventive care such as immunizations and cancer screenings, women can avoid the development of more complicated and costlier health problems in the future. We applaud the focus on preventing illness and disease across public and private sectors of the health care system. The proposed policies to structure cost-sharing to encourage the use of

preventive services are a key step to increasing the receipt of such care, but the evidence shows that even nominal cost-sharing can serve as a barrier to necessary preventive care for health plan enrollees. Therefore, we urge the Committee to *prohibit* cost-sharing entirely for these services to ensure that costs are not a barrier to care. In addition, we support the plan to provide states with funding to guarantee immediate access to preventive care and chronic disease management services for uninsured women and their families while more permanent coverage options are being developed through the Exchange.

There must be adequate protections to assure that workplace wellness programs are not essentially punitive in nature for those who choose not to participate. In addition, these programs must allow maximum flexibility for those who juggle multiple obligations outside of their workplace, such as working women with families, or people with multiple jobs.

## **VII. Long Term Care Services**

- **Proposals that encourage use of home and community based services would assist women both as Medicaid beneficiaries, and as caregivers.**

The Coverage Policy Options include a series of proposals that would facilitate the receipt of cost-effective home- and community-based services (HCBS) by more Medicaid beneficiaries, such as an option to increase the FMAP for HCBS, an option to apply Medicaid rules that prevent spousal impoverishment more broadly to HCBS, and an option to allow HCBS applicants to retain higher levels of assets and still qualify for services. An additional proposal would encourage the delivery of HCBS to all community members (beyond the Medicaid program) via HHS-provided grants to eligible states for initiatives including increased support for informal caregivers.

Women live longer than men, on average, and they are more likely to be the “community spouses” who risk impoverishment and asset depletion when their spouse applies for long-term care services through Medicaid. Women also comprise a majority of adult beneficiaries in the Medicaid programs (including those who are dually-eligible for the Medicaid and Medicare programs). For all of these reasons, women will benefit greatly from increased access to long-term care services (both covered by Medicaid and through community-based grants) that allow them and their family members to receive necessary health benefits while still remaining in their communities and maintaining a high quality of life. Furthermore, women are more likely than men to serve as informal caregivers for an ill or disabled family member, and we applaud any initiative that would increase support for such caregivers, as this proposal will have a positive impact on women’s well-being.

Given the likely increased demand for home and community based services, and the great need to expand this workforce to meet this increased demand, we encourage the Committee to adopt various quality improvement and workforce recruitment and retention mechanisms, such as increased training, and salary and benefit enhancements, to meet this growing demand.

## VIII. Options to Address Health Disparities

Recognizing that significant health disparities exist between women and men, as well as among women, **we strongly support the options included in the Coverage paper which aim to address these inequalities.**

- **Data Collection and Reporting:**

Gaps in health data collection—including data collected through national or state surveys and by health plans and providers—limit the scope of medical research on women and prevent informed decision making about policies and resources that affect women. While there has been improvement in women’s health data collection, some critical gaps remain, especially with regard to state-specific data, data for subpopulations of women, and data on the quality of women’s health care. The proposed options to improve data collection and reporting would significantly contribute to filling the existing gaps. In particular, we support:

- The option to require the Social Security Administration to collect race, ethnicity, and language data by gender, which could help identify quality disparities among different groups of women enrolled in Medicare.
- The option to require federally funded population surveys to collect sufficient data on racial/ethnic subgroups by gender, and would allow for robust analyses to identify health disparities in access and quality among all women.
- The option to establish standardized categories for collecting data on race and ethnicity by gender, which would establish uniformity in collecting data on racial/ethnic subpopulations among women.
- The option to require that health quality data be published by race, ethnicity, and gender, which would allow women to compare quality among health plans and hospitals and make choices that best fit their health care needs.

While these improvements in data collection and reporting will do much to address gaps in access to and quality of health care, we encourage the Committee to consider other populations that suffer disparities in health status and the critical role that data collection and reporting play in reducing these inequities. In particular, we urge the Committee to address the lack of data on access to health care and the health status of lesbian, gay, bisexual and transgender Americans. Including sexual orientation and gender identity as categories within data collection and reporting efforts are crucial first steps to ameliorating the significant health disparities these populations currently experience.

- **Language Access:**

- **Increase in FMAP rate for translation services:**

We support the coverage option to extend the 75% matching rate for translation services to all Medicaid beneficiaries for whom English is not their primary language. Improved translation and interpretation services in Medicaid would contribute to ensuring that all Medicaid patients, 70% of whom are women, have access to quality care when they need it.

- **Language access services:**

The proposed option would also establish standards for providing culturally and linguistically appropriate services (CLAS) that would apply to private insurers in the Health Insurance Exchange. In addition to setting out standards, however, it is important that health care reform establish adequate enforcement mechanisms to ensure that private insurers comply with new standards. Proper CLAS standards that are effectively enforced helps ensure that patients have access to quality health care, care that is free of language barriers which often lead to negative health outcomes due to poor communication and poor decision-making by both providers and patients.

- **Elimination of Five-year Waiting Period for Non-Pregnant Adults:**

We strongly support the proposed option to eliminate the five-year waiting period for non-pregnant adults seeking to access Medicaid coverage. This option would remove a significant and arbitrary barrier to ensuring that all eligible legal residents have access to Medicaid, a critical program for low-income women.

- **Reducing Infant Mortality and Improved Maternal Well-Being:**

We commend the proposal to encourage innovative state approaches to reducing infant mortality. Infant mortality rates are a primary indicator of a population's health, and the persistent disparities in rates among populations are unacceptable. Targeted, multidisciplinary approaches to address these disparities—especially those that seek to improve the overall health status of reproductive-age women—can greatly benefit women's health and well-being.

## **Summary of Recommendations**

In addition to our support of many of the Coverage Options as detailed above, below is a summary of our recommendations to strengthen many of these Options.

### **I. Insurance Market Reforms**

- Non-group, Micro-Group and Small Group Market Reforms
  - Apply proposed insurance market reforms to the sale of all health insurance products – not just limited to individual and small group markets.
  - The proposed rate variation for age (5:1) should be eliminated or, at a minimum, significantly reduced to assure that the cost of health insurance doesn't increase for older individuals.
- Health Insurance Exchange
  - Small employer groups should be rated as a group when participating as an exchange, rather than rating each individual employee.
  - Allowing multiple exchanges to compete would be confusing for consumers trying to compare multiple health plan options, and would undermine the benefit of creating larger pools of people to insure.
  - Exchange-participating insurance plans should have adequate provider networks that include essential community providers.
- Transition

Reduce the time allowed for state implementation of small group market rating changes to be consistent with time frames for implementation of non-group and micro-group reforms.

- State Insurance Commissioners  
Adopt specific protections to ensure that geographic areas as defined by state insurance commissioners are not drawn in discriminatory ways.

## **II. Making Coverage Affordable**

- Benefit Options
  - Adopt a mechanism to through which a panel of experts, consumer advocates and other key stakeholders determine the details of the required benefit package.
  - Eliminate the fourth “lowest” tier benefit package to simplify coverage choices, and avoid offering health plans that would leave people at great financial risk.
  - Adopt adequate oversight mechanisms to ensure that approved benefit packages in the different coverage tiers are truly comprehensive and remain so over time, with strong affordability protections to avoid cost- shifting to individuals and families through modifications in benefit design.
  - Deductibles must be prohibited or significantly limited, and there must be caps on out-of-pocket costs for all exchange enrollees.
  - Cost-sharing should be prohibited for preventive services; any definition of preventive services should include family planning services.
- Low-Income Tax Credits
  - Tax credits should be available to assist with both premiums and out-of-pocket cost.
  - The value of tax credits must vary to allow for any permitted premium rating factors (such as age or geography).
- Small Business Tax Credits
  - Simplify the tax credit to ensure maximum participation.
  - Allow non-profit organizations to apply the tax credit to payroll tax liability.

## **III. Public Health Insurance Option**

*We strongly support the inclusion of a public health insurance plan option. Of the options presented, we prefer “Approach 1: Medicare-Like Plan.”*

## **IV. Role of Public Programs**

- Medicaid
  - Establish a clear minimum eligibility floor for childless adults.
  - Ensure that States’ commitments to currently eligible Medicaid populations not expire until those beneficiaries have access to other affordable, sufficiently comprehensive coverage options.
  - Regarding the interplay between Medicaid and an Exchange, we strongly support Approach 1, which would avoid disruption of care arrangements for Medicaid beneficiaries and prevent difficulties in receiving coordinated care.

- Medicare
  - Provide low-income tax credits to provide financial assistance to those opting for the temporary Medicare buy-in.

## **V. Shared Responsibility**

- Personal Responsibility
  - Personal responsibility requirements should not be implemented until after all insurance market reforms have occurred.
  - Extend the initial open-enrollment period.
  - Provide an alternative pre-existing condition exclusion period that would not disproportionately hurt women by using a nine month period that would completely exclude pregnancy.
- Employer Responsibility
  - Any employer responsibility requirement should apply to all employees proportional to hours worked, not based on full-time status.

## **VI. Prevention and Wellness**

- Prohibit cost-sharing for preventive care.
- Ensure that wellness programs are not inherently punitive and allow maximum flexibility for employees with multiple obligations outside of their employment.

## **VII. Long Term Care Services and Supports**

- Adopt workforce training, recruitment and retention mechanisms to meet increased demand for expanded home and community based services.

## **VIII. Options to Address Health Disparities**

*We applaud the inclusion of multiple options that would address health disparities.*

- *Expand data collection by gender and subpopulations; this option should be expanded to include data collection and reporting for LGBT populations.*
- *Increase the FMAP rate for translation services in Medicaid;*
- *Add enforcement mechanisms to ensure that private insurers operating in the Exchange are following standards that would be established for culturally and linguistically appropriate services;*
- *Provide a state option to eliminate the five-year bar in Medicaid for legally residing residents;*
- *Reduce infant mortality and improve maternal well-being.*

We thank you again for the opportunity to comment. We look forward to working with you and the members of your Committee to adopt health reform that will result in improved access to comprehensive, high-quality, affordable health care for all women and their families.

Sincerely,

National Women's Law Center  
 American Association of University Women  
 Black Women's Health Imperative

Childbirth Connection  
Maryland Women's Coalition for Health Reform  
National Coalition for LGBT Health  
National Council of Jewish Women  
National Council of Urban Indian Health  
National Family Planning & Reproductive Health Association  
National Partnership for Women and Families  
National Women's Health Network  
Ovarian Cancer National Alliance  
OWL – The Voice of Midlife and Older Women  
PHI *Health Care for Health Care Workers* Campaign  
Physicians for Reproductive Choice and Health  
Planned Parenthood Federation of America  
Raising Women's Voices for the Health Care We Need  
YWCA USA  
The Women's Collective