

# **WOMEN'S LAW PROJECT**

**Safeguarding Rights, Creating Opportunities**

**COMMENTS OF WOMEN'S LAW PROJECT**

**PRESENTED TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**ON**

**ESSENTIAL HEALTH BENEFITS UNDER THE PATIENT PROTECTION AND  
AFFORDABLE CARE ACT**

**PHILADELPHIA LISTENING SESSION**

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**Submitted by**

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## COMMENTS ON ESSENTIAL HEALTH BENEFITS

I appreciate the opportunity to present comments to HHS implementation of its obligation to define the scope of benefits provided in the ten categories identified as “essential health benefits” under Section 1302 of the Affordable Care Act (ACA). The Women’s Law Project (WLP) is a legal advocacy organization that engages in high impact litigation, advocacy and education to advance the rights and status of women. Improving access to comprehensive, quality, and affordable health care for women is one of many arenas in which the Women’s Law Project advocates on behalf of women. By delegating to HHS the definition of essential health care services, the ACA provides HHS with an opportunity to make a huge difference in the lives of women, consistent with the ACA’s statutory charge to take into account the health care needs of women<sup>1</sup> and prohibiting gender discrimination.<sup>2</sup> In furtherance of WLP’s interest in eliminating insurance discrimination against women and expanding insurance coverage to address women’s essential needs, I will incorporate responses to several of the questions posed for consideration for today’s listening session into comments emphasizing concerns related to women’s health.

- **Balancing Comprehensiveness of Coverage and Affordability**

The Institute of Medicine (IOM) has recommended that HHS take cost into account as it defines the essential health care package and to start with a typical small employer market plan. We think this is the wrong place to start. In the first place, the ACA does not charge HHS to start from the cost perspective. Rather the charge is to define essential health care benefits. The ACA offers other mechanisms for addressing cost, including premium rate review, limits on premium increases, and improvements in delivery of care that should promote competition and hold down costs.<sup>3</sup> IOM’s report acknowledges that exchange participation will “bring the purchasing power of larger groups to the marketplace and, ideally, offer more comprehensive coverage for what small employers are now paying ...”

Second, starting with the current costs of insurance will only serve to imbed the limitations on benefits that we have been living with and undermine the goal of the ACA to expand affordable insurance coverage. Providing essential health care will save money in the long term. Individuals will receive timely and appropriate care which will avoid more expensive care they would otherwise need.<sup>4</sup> For example, the expanded provision of contraceptive care already approved by HHS will eliminate the greater costs of pregnancy-related care.<sup>5</sup> These savings will likely reduce the cost of the insurance package that IOM recommends as the starting place, rendering inaccurate the assumptions upon which the essential benefits were defined. Classifying essential health benefits broadly will also save public expenditures on government programs which may be relied upon when essential care is not covered by insurance.

HHS’ goal in defining essential health benefits should be to maximize benefits and take advantage of cost-savings from providing more comprehensive benefits.

- **Ensuring an Appropriate Balance Among Categories of Essential Health Benefits**
- **Preventing Discrimination.**

WLP believes that HHS should provide comprehensive coverage for all categories of essential health benefits, including coverage for a full continuum of care needed for specific conditions. Congress intended for a comprehensive set of benefits that would correct longstanding coverage gaps in the individual and small group markets, as evidenced by the fact that maternity care, mental health and substance abuse services — categories that are routinely not covered by insurance plans — are explicitly included as categories in the package. The EHB package must be a strong federal floor. The Secretary should develop a consistent, specific, and standard benefit package. In developing this package, HHS should consider clinical evidence, best practice standards of care, and the health care needs of patients, particularly populations historically underserved by insurance.

When determining whether the essential health benefit package meets women’s needs in particular and addresses historical sex discrimination in insurance, HHS should consider recommendations issued by professional organizations of health care providers that care for women across their lifespan, including the American College of Obstetricians and Gynecologists (ACOG), which issues regularly-updated recommendations related to reproductive health care for women and adolescent girls, and the American Academy of Family Physicians, which also issues clinical recommendations for preventive services, obstetrics, and other health care areas important to women’s health. We also ask that you specifically consider the particular importance of providing and specifically defining coverage for comprehensive maternity and behavioral health services for women. Research we have undertaken for a soon to be published report on women’s health provides compelling evidence for the need for defining these benefits specifically and comprehensively.

### **Maternity and Newborn Care**

The inclusion of maternity and newborn services as an essential health benefit is a given. There can be no debate that such services are in fact essential to women. However, the term “maternity” is not defined in the ACA and is susceptible to several meanings. This is one area where IOM’s recommendation of specificity should clearly be followed. The term “maternity coverage” could be interpreted as including any single or combination of the following elements of pregnancy-related health care: hospitalization and care for delivery, prenatal care, and postpartum care. Whether HHS defines the term comprehensively or not will make a dramatic difference in the lives of women and their newborns. Leaving the term undefined will potentially leave women without critical health care.

Comprehensive maternity care is important for effectively protecting the health of the pregnant woman and her newborn. Despite the enormous benefit of prenatal care, only 79.4% of women in Pennsylvania who gave birth in 2008 received prenatal care in the first trimester, below the U.S. Healthy People 2010 target of 90%.<sup>6</sup>

Early initiation of prenatal care allows the medical provider to diagnose any problems with the pregnancy as soon as possible. It also gives the medical provider an opportunity to

educate women about behavioral risks, such as smoking and poor nutrition<sup>7</sup> and prescribe essential vitamins and treatment for infections that may prevent spina bifida<sup>8</sup> and passage of HIV and other infections to the child.<sup>9</sup> Furthermore, prenatal care can prevent and monitor pregnancy-related conditions such as gestational diabetes, high blood pressure and placental problems which can harm women's and newborns' health. It connects women with high-risk pregnancies to life-saving obstetrical and neonatal care.<sup>10</sup>

Adequate prenatal care is critically important for reducing the maternal mortality rate. In Pennsylvania, there were 86 maternal deaths between 2004 and 2008, constituting 11.7 maternal deaths per 100,000 live births in Pennsylvania.<sup>11</sup> Since 2000-04, the maternal mortality rate jumped from 9.8 to 11.7, with more than twice as many African-American women dying than white women.<sup>12</sup>

Maternal health affects fetal health. Some studies have shown that access to early and continuing prenatal care reduces the likelihood of preterm delivery.<sup>13</sup> Prematurity accounts for one-third of all infant deaths in the first year of life,<sup>14</sup> and is the leading cause of perinatal mortality.<sup>15</sup> Women who receive no prenatal care are three times more likely to give birth to a baby of low birth weight,<sup>16</sup> which is often associated with perinatal mortality.<sup>17</sup> Prenatal care is cost-effective relative to the high costs of newborn intensive care and long-term institutional care.<sup>18</sup>

Postpartum care is recommended by the American Academy of Pediatrics and ACOG, because they believe that it provides "important opportunities to assess the physical and psychosocial well-being of the mother, counsel her on infant care and family planning, and detect and give appropriate referrals for preexisting or developing chronic conditions such as diabetes, hypertension, or post-birth depression."<sup>19</sup> Postpartum conditions that may last for a year or longer include postpartum depression, breastfeeding, bladder/bowel dysfunction, and concerns about sexuality and contraception.<sup>20</sup> As short intervals between pregnancies may lead to low birth weight and preterm birth, contraceptive counseling is particularly important in this post-birth period when pregnancy may occur.<sup>21</sup>

The only way to provide appropriately balanced maternity and newborn coverage is to require coverage of the full continuum of care required by women with either low or high risk pregnancies.

### **Mental Health and Substance Use Disorder Services**

Mental health and substance use disorder services are also particularly critical for women's health. While researching our soon to be published report on women's health, the WLP found that women's health is inseparable from the discrimination and disproportionate burdens placed on them as a result of bias and stereotypes imposed on them in our homes and communities, schools and workplaces, and in the health care system. As a consequence, women are suffering from mental health and substance use disorders for which they are sorely in need of access to medical care. Specifically, we found that:

- Long-held gender-based stereotypes and hostility towards women leads to the sexual and domestic abuse of women, which often cause long term mental health consequences, including post traumatic stress disorder, anxiety, suicide attempts, substance use, and eating disorders.<sup>22</sup>
- Women are disproportionately burdened by poverty and, as a consequence, experience the health risks and conditions associated with poverty, including post traumatic stress disorders as well as depression and anxiety disorders. Women living in poverty are often unable to access even basic health care for themselves and their families let alone behavioral health care.<sup>23</sup>
- Sex stereotyping leads to a disproportionate share of caretaking falling on women and causing them to experience high rates of depression and anxiety.<sup>24</sup>
- Ongoing discrimination in the workplace in pay and occupation and based on pregnancy, caretaking, and domestic and sexual violence leads to an array of psychological health problems, including depression and post traumatic stress.<sup>25</sup>
- Young women, subjected to unequal opportunity in sports and sexual victimization in school are at risk for a wide range of psychological harms, including anxiety, substance use, suicidal thoughts, depression, eating disorders, long-term depression and post traumatic stress disorder.<sup>26</sup>

Appropriate, high quality behavioral health care for mental and substance use problems and illness has been found to be both effective and cost-effective.<sup>27</sup> Yet, millions of women go without care, with consequences for families. The behavioral health coverage should be structured to enable women to access gender-specific, culturally competent, and trauma-informed behavioral health prevention and treatment services.

### **Additional Essential Health Benefits**

The Women’s Law Project applauds HHS’ decision to require coverage of a number of women’s preventive health care services, including the full range of FDA-approved contraceptive methods, counseling, and patient education, with no out-of-pocket costs. We urge HHS to include women’s preventive health services in the essential health benefit package. We wish we could be talking about the full range of women’s reproductive health care needs today and regret that statutory restrictions on access to abortion services have prevented the ACA from addressing all of women’s essential health care needs.

### **Addressing Benefit Limitations and Cost-Sharing**

Once the contours of the essential health benefits are defined, it will be necessary to insure that the benefits are real and not illusory. This can only be accomplished by restricting insurer discretion on benefit limitations and cost-sharing, so that those covered by the plans are in a position to truly take advantage of them. Health plans should not be permitted to impose deductibles and copays that make the service unaffordable. Nor should they be permitted to

institute impossibly low thresholds of allowed services, such as low numbers of allowed inpatient hospital days or number of counseling sessions.

## Conclusion

Both the ACA mandate to take into account the needs of women and children and the prohibition on discrimination on the basis of sex support coverage definitions and requirements that comprehensively address women's reproductive and behavioral health care needs.

Thank you for your consideration of these comments.

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<sup>1</sup> Affordable Care Act, § 1302(b)(4) (2010) (codified at 42 U.S.C. § 18022).

<sup>2</sup> *Id.* at § 1557 (codified at 42 U.S.C. § 18116).

<sup>3</sup> Families USA, *The Bottom Line: How the Affordable Care Act Helps America's Families* (2011), available at <http://www.familiesusa.org/resources/publications/reports/health-reform/helping-families.html>.

<sup>4</sup> Families USA, *Issue Brief: Limited-Benefit Plans: Expanding Coverage or Holding Your State Back?* (2008), available at <http://www.familiesusa.org/assets/pdfs/limited-benefit-plans.pdf>.

<sup>5</sup> Every dollar invested in public dollars for contraception saves an estimated \$3.74 in Medicaid expenditures that otherwise would have been needed to provide pregnancy-related care (prenatal, labor, delivery and postpartum care), as well as one year of medical care for their infants. In fact, according to an employee benefits consulting firm, it costs employees 15-17% more not to cover contraceptives than to provide such health coverage (accounting for medical costs of pregnancy and maternity leave). See Adam Sonfield, *Contraception: An Integral Component of Preventive Care for Women*, 13 *Guttmacher Policy Rev.* 2 (2010).

<sup>6</sup> Pennsylvania Dep't of Health, *Focus Area 16, Objective 16-06a, Family Health Statistics for Pennsylvania and Counties 27* (2010), available at <http://www.portal.state.pa.us/portal/server.pt?open=514&objID=596010&mode=2>.

<sup>7</sup> Dave E. Williams & Gabriella Pridjian, *Obstetrics*, in Robert E. Rakel & David P. Rakel, *Textbook of Fam. Med.* 363 (Elsevier Inc., 2011) ("Adequate prenatal care has been shown to increase the chances that a woman has a healthy pregnancy and baby.").

<sup>8</sup> Folic acid reduces the risk of spina bifida, a birth defect affecting the spinal cord in the child. See J. David Erickson, *Folic Acid and Prevention of Spina Bifida and Anencephaly*, 51 *Morbidity & Mortality Weekly Rep.* 1 (2002), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5113a1.htm>.

<sup>9</sup> Kristine Patterson, et al. *Frequent Detection of Acute HIV Infection in Pregnant Women*, 21 *AIDS* 2303 (2007); see, e.g., K.J. Perozzi, et al., *HSV: What You Need to Know to Care for Your Pregnant Patient*, 32 *Am. J. of Maternal/Child Nurs.* 345, 348-49 (2007).

<sup>10</sup> M.C. McCormick & J.E. Siegel, *Recent Evidence on the Effectiveness of Prenatal Care*, 1 *Ambulatory Pediatrics* 321 (2001); Williams & Pridjian, *supra* note 7, at 373-74, 380-81.

<sup>11</sup> Pennsylvania Dep't of Health, *supra* note 6, at 26.

<sup>12</sup> *Id.*

<sup>13</sup> Jay D. Iams & Roberto Romero, *Preterm Birth*, in Steven G. Gabbe, et al., *Obstetrics: Normal and Problem Pregnancies* 668, 673 (Churchill Livingstone, 2007).

<sup>14</sup> William M. Callaghan, et al. *The Contribution of Preterm Birth to Infant Mortality Rates in the United States*, 4 *Pediatrics* 1566 (2006).

<sup>15</sup> Iams & Romero, *supra* note 13, at 670.

<sup>16</sup> Richard L. Fogel, U.S. General Accounting Office, *Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care, Report to the Chairman, Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, House of Representatives* 3 (Sep. 30, 1987).

<sup>17</sup> Iams & Romero, *supra* note 13, at 672-3; Fogel *supra* note 16, at 13.

<sup>18</sup> Fogel, *supra* note 16, at 64 ("for every dollar spent on prenatal care for high-risk women, over three dollars could be saved in the cost of care for low birth-weight infants.").

<sup>19</sup> S.Y. Chu, et al., *Postpartum Care Visits—11 States and New York City, 2004*, 56 *Morbidity & Mortality Weekly Rep.* 1312 (2007), (citing American Academy of Pediatrics, American College of Obstetricians and Gynecologists.

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Guidelines for Perinatal Care (American College of Obstetricians and Gynecologists, 2007)), *available at* <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5650a2.htm>.

<sup>20</sup> Elizabeth Shaw & Janusz Kaczorowski, *Postpartum Care – What’s New?*, 19 *Current Opinion in Obstetrics & Gynecology* 561 (2007).

<sup>21</sup> *Preconception and Interconception Health Status of Women Who Recently Gave Birth to a Live-Born Infant-Pregnancy Risk Assessment Monitoring System (PRAMS)*, 56 *Morbidity & Mortality Weekly Rep.* 1, 13-14 (2007).

<sup>22</sup> Nat’l Ctr. for Victims of Crime, *Acquaintance Rape*,

<http://www.ncvc.org/NCVC/main.aspx?dbName=DocumentViewer&DocumentID=32306#references> (last visited June 6, 2011); Dean G. Kilpatrick et al., *Drug-Facilitated, Incapacitated, and Forcible Rape: A National Study* 51-52 (2007), *available at* <http://www.ncjrs.gov/pdffiles1/nij/grants/219181.pdf>; U.S. Dep’t of Health & Human Servs., *Substance Abuse Treatment: Addressing the Specific Needs of Women* 22 (2009), *available at*

<http://www.kap.samhsa.gov/products/manuals/tips/pdf/TIP51.pdf>; Maria A. Pico-Alfonso, et al. *The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women’s Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety, and Suicide*, 15 *J. of Women’s Health* 599, 603 (2006); Jacqueline Campbell, *Health Consequences of Intimate Partner Violence*, 359 *Lancet* 1331, 1334 (2002); Bonnie S. Dansky et al., *The National Women’s Study: Relationship of Victimization and PTSD to Bulimia Nervosa*, 21 *Int’l J. Eating Disorders* 213, 220 (1997).

<sup>23</sup> Usha Ranji et al., Hendy J. Kaiser Family Found., *Women’s Health Care Chartbook: Key Findings from the Kaiser Women’s Health Survey 1* (2011); Mariana Chilton, et al., *Evidence That Young Children Are Falling Through the Safety Net: Policy Implications of Hunger and Poor Health in Pennsylvania*, 14 *Commonwealth: A J. of Political Science* 55, 56 (2008).

<sup>24</sup> Karen Saban et al., *Measures of Psychological Stress and Physical Health in Family Caregivers of Stroke Survivors: a Literature Review* 42 *J. Neuroscience Nursing* 3, 128-138 (2010); Anne Forster, *Caregiver Burden in Stroke*, 9 *Current Medical Literature: Stroke Rev.* 1, 127-131 (2005); Mary Mittleman, *Community Caregiving*, 4 *Alzheimers Care Today* 273 (2003); Family Caregiver Alliance, *Fact Sheet: Women and Caregiving* (2003).

<sup>25</sup> Kimberly Matheson et al., *Cortisol and Cardiac Reactivity in the Context of Sex Discrimination: The Moderating Effects of Mood and Perceived Control*, 1 *Open Psychol. J.* 1, 8 (2008).

<sup>26</sup> Don Sabo et al., Women’s Sports Found., *Her Life Depends On It: Sport, Physical Activity and the Health and Well-Being of American Girls* 22-23 (2004), *available at* <http://www.womenscolleges.org/files/pdfs/Womens-Sports.pdf>; Rana Sampson, U.S. Dep’t of Justice, *Acquaintance Rape of College Students* 2 (2003), *available at* <http://www.cops.usdoj.gov/files/RIC/Publications/e07063411.pdf>.

<sup>27</sup> *See, e.g.*, Alexander Blount, et al., *The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence*, 38 *Prof’l Psych. Research & Practice* 290, 292 (2007); U.S. Dep’t of Health and Human Servs., *Substance Abuse and Mental Health Servs. Admin. Ctr. for Substance Abuse Prevention, Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis* 33 (2008), *available at* <http://store.samhsa.gov/shin/content/SMA07-4298/SMA07-4298.pdf>.