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An Early Look at the Affordable Care Act and Women's Health
Kaiser Family Foundation
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ALINA SALGANICOFF: Good morning, everyone. I am Alina Salganicoff, and I am Vice President and Director of Women's Health Policy here at the Kaiser Family Foundation and on behalf of the Foundation, I'd like to welcome you here to the Barbara Jordan Center.

As many of you know, this week is actually Women's Health Week and we thought this would be a very auspicious time to release the survey findings, but what I didn't know is that there was also going to be some other really big women's health news this week. Did you all see the news about the NIH announcement that now they are going to be required to include female animals in research? I want to say as someone who does women's health research this is actually a really, really huge development and advancement and that is only coming 21 years after the NIH Revitalization Act that required that women be included in clinical trials.

I say that as there's a lot to celebrate but a lot of changes take time and I think we're here today to try to learn about what the ACA is going to do in terms of its impact to women but I think that it's important to keep our expectations and what we're going to see in context here.

While this survey was conducted last fall and really it was just before the Affordable Care Act coverage expansions were really getting into full gear. This is the fourth in a

series of surveys that the Foundation has conducted on women's health. We started our first in 2001. Our goal with this particular survey was really to provide an initial look at the range of women's healthcare experiences at a time of transition and especially to focus on those issues that are important to women that are typically not addressed by other surveys nor are they often analyzed through a gender lens.

We also wanted to understand the challenges facing different populations of women; women of color, low-income women, and uninsured women. As many of you in the room know, the passage of the ACA really did herald a new era in healthcare coverage and with major implications for women's health coverage and access to care. The ACA has many provisions that were designed to really address long standing gaps and inequities in health insurance. Provisions such as now the mandatory inclusion of maternity care in health plans, the bans on pre-existing condition exclusions that affected women who were pregnant or victims of intimate partner violence, or those who had chronic medical conditions. Now, we have mandatory coverage in new plans, preventive services without cost sharing for a wide range of services, as well as specific preventive services for women, eight of them including contraceptive coverage but also now screenings for intimate partner violence, well-women visits, and breastfeeding support.

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Many of these elements of this law were developed with the health needs of women in mind. Some of the provisions were implemented shortly after the passage of the law including the expansion of dependent coverage and some of the preventive services coverage rules. The requirement for mandatory insurance coverage and the expansion of Medicaid in the Marketplace puts plans and the bans on the pre-existing condition exclusions and gender rating are just getting underway.

They have the possibility, I think, of not only changing the way uninsured women get their care but also may shape how insured women get their care in the future. What we'd like to do today is provide you with a first look at the health coverage and access experiences of women at a point of transition; the very earliest days of ACA. Understanding the full impact of the law and access to care is going to clearly take many years as will its full implementation but I think it's important to know where we are today and to have a baseline for which we can compare future outcomes.

Today my colleague and report co-author, Usha Ranji, who is Associate Director of Women's Health Policy here at the Foundation, will share with you some of the highlights of the report. They provide a look at women's coverage, identify costs and other barriers to care, examine women's use of

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preventive services, as well as sexual and reproductive healthcare.

Before we get started with the program, I did want to take just a moment to really extend my deep appreciation to Usha and to Adara Beamesderfer, who is one of my co-authors and to Nisha Kurani, who is in California, for all their work in getting this report prepared, thank you.

We are then going to have a panel discussion with a group of real experts in women's health to help us put these findings into context, especially at a time of great change and then we're going to open the discussion with you, the audience.

To help us have our discussion today, we've invited a very distinguished group of leaders in women's health. To my right here is Amy Allina, who is the Deputy Director of the National Women's Health Network and Co-Founder of Raising Women's Voices for the healthcare we need, which is the national initiative of women's organizations from across the country that are making sure that women's voices are heard and their concerns are addressed under the ACA.

We are then joined by Dr. Francisco Garcia, Director, and Chief Medical Officer of the Pima County Health Department in Arizona, really on the front lines of public health and the ACA implementation. Dr. Garcia is also a member of the US Preventive Services Task Force and also continues to serve on the faculty at the University of Arizona where he in prior

years directed the University of Arizona Center for Excellence in Women's Health. He also served with me on the IOM committee on preventive services for women.

We are then also joined by Dr. Cara James. She's the Director of the Office of Minority Health at CMS and also former Kaiser colleague who directed the Kaiser Foundation's Healthcare Disparity's Project and the Barbara Jordan Scholar's Program.

Finally, we're very lucky to have Dr. Vanessa Cullins, who is the Vice President of External Medical Affairs, the Planned Parenthood Federation of America. She has had a distinguished career focusing on improving women's sexual and reproductive health and has focused her work on a global, national, and local level. I really don't have time to do justice to the distinguished careers of our panelists but I encourage you to review their bios, which are in the packages behind the chart pack.

Without further delay, now I'm going to turn it over to Usha.

USHA RANJI: Good morning, everyone. Thank you, Alina, and thank you all for joining us today. Like Alina said, we undertook this survey to get the perspectives of women and get a snapshot of their experiences with coverage and care at a really pivotal time for the healthcare system, in the early

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years of ACA implementation and just before the major coverage expansion took affect in January this year.

Briefly a little bit about the methods, the data in the report that you have and that I'm going to share today are based on a nationally representative survey of women ages 15 to 64, over 3,000 women. We were very pleased to work with Princeton Survey Research Associates who actually carried out and conducted the survey. We included oversamples of low-income women, and women of colors to make sure that we wanted to be able to report on these populations. Today, we're able to report on experiences for White, Black, and Hispanic women. We know that that is limited but that's what we were able to include with the sample.

We did also conduct a shorter companion survey of 700 men to be able to have some data for comparison and when we talked to women we asked them about a range of issues related to their healthcare, in particular experiences with coverage, healthcare costs, access and barriers, and also their use of specific services, particularly around prevention and reproductive and sexual healthcare services and for that I'll be reporting findings for women of reproductive ages, 15 to 44.

Starting with their health, which sets the framework for the care that women need and that they seek, overall, 15-percent of women ages 18 to 64 rate their health as fair or poor. About the same share say that they have a disability or

some sort of condition that limits their daily activities. I think what's important here is really the difference in health status between women of different income levels. Rates at least twice as high as for those who are low-income and this is just particularly relevant for us to keep in mind given the ACA's focus on healthcare affordability.

One of the other issues that we did ask about is the extent to women report that they have a condition that requires ongoing care or treatment, such as a medication. This is the case for about four in 10 women. Here we really don't see a difference. I think it is, again, important to consider the access factor of course though because receiving diagnosis of course requires getting into care sort of predicated on that and so that is part of the issue because we also know for many years that low-income women do have poorer access.

Of course the focus of the ACA is on coverage and so here we have a profile of women's coverage in late 2013 just before the major expansion went into affect. Over half of non-elderly adult women were covered by employer-sponsored insurance, either through their own job or as a dependent of their spouse or a parent. Just 7-percent purchased individual coverage on their own and about one in 10 in this group were covered by Medicaid. That leaves about one in five non-elderly adult women uninsured. Over time, as the ACA's coverage expansion now takes full affect, we expect that this profile is

going to change, particularly as a result of the Medicaid expansion that is happening in at least half the states and those who purchase coverage in the newly-opened state-based Marketplaces.

When we dig down we do see large disparities in women's coverage between different groups. While most women are covered by employer-sponsored insurance that is not the case for Black and Hispanic women who have much higher rates of Medicaid coverage; about twice the rate as White women, also a much higher rate of uninsured, which is the case of over one-fifth the Black women and over a third of Hispanic women. This, of course, reflects in part the lower incomes and access to employer-based coverage for these communities.

While most of the ACA's coverage expansion is really being rolled out now, one provision as Alina mentioned that did go into affect soon after the law was passed was the extension of dependent coverage up to age 26, which allowed many young adults to remain on their parent's plan. What we see now is that over four in 10 women ages 18 to 25 are covered on their parent's plan. It's now the leading way that this group of young adult women obtain insurance.

Now that that is the case, I think it's really important to consider what this means for this group; the group that’s entering adulthood, gaining independence. It's a typical practice for private insurance plans to send an

explanation of benefits or an EOB to the principal policyholder that usually documents the services that were used. Many in this age group are not aware of that though, and also it's about a third in this group know that. Yet, this is also the group that rates confidentiality as the most important thing that they really do want details about their use of services such as family planning or mental health services to be kept confidential. Going forward, I do think we'd also need to think about how we maintain privacy and maintain confidentiality for this group.

Obviously, while coverage plays a large role in accessing care, health care costs, premiums, co-payments, et cetera, are another major concern for women and focus of the ACA. Women and men both feel the impact of out-of-pocket costs. They are burdensome though for a higher share of women, with about a quarter of women saying that they've had to delay or go without care that they needed because they couldn't afford it. Many also report that they've had to make some sort of trade off, either skipping a test that was recommended for them or skipping a medication dose because they could not afford the costs. We know, overall, compared to men women on average have fewer financial assets, higher rates of poverty, and also at the same time women use healthcare more and have higher medical expenses across their lifetime. I think it's also important to note that about three in 10 women say that

they had problem paying their medical bills, which can have a spill-over affect into other parts of their finances.

This is in some ways is not really surprising. Cost-related barriers are much more common among the uninsured. We've known that for a long time. In some cases three to four times the rate, really limiting an insured woman's ability to obtain and use care. I think it's also important to recognize that some women with insurance still cannot afford care. We have 16-percent of women with private insurance and about a third of women covered by Medicaid report that they had to postpone or delay care because they couldn't afford the out-of-pocket costs. And in particular for women with Medicaid, most states allow what we usually consider very nominal cost sharing but there are other limits such as some states do limit the number of prescriptions that can be filled and for a population that by definition is very low-income, even what we sometimes consider nominal, can be a barrier to care.

We cannot view healthcare in isolation. There are many factors that affect women's access, issues such as finding time to get to care or the ability to take time off work and that in particular, a quarter of low-income women postponed or went without care because they couldn't take time off work. For many women getting to the doctor can be a challenge and that’s not something that we always think about, but nearly one in five low-income women cited transportation is a reason for

going without or postponing care. Also, women's roles as mothers comes into play. One in 10 moms in the higher income group report that they delayed their care because they had problems getting childcare and the rate is almost twice as high for low-income women.

These are issues that are not necessarily directly addressed by the ACA, so as our healthcare system changes, I think this really just reminds us how strongly women's access to care intersects with other very important public policy debates.

We also asked women about the services that they are receiving, particularly around prevention and reproductive health. One of the ACA's major provisions was the requirement that all new private plans cover recommended preventive services without cost sharing. This includes a range of screening tests as well as counseling on a variety of public health and healthcare topics. While we see that overall most women have had recent screening tests for blood pressure and breast and cervical cancers, again, maybe not surprisingly across the board the rates are much lower for uninsured women; just another indicator of their poor access.

Many of the preventive services that are now covered without cost sharing are related to reproductive and sexual healthcare. We asked women of reproductive age, that's 15 to 44 years old, about whether they had had a recent conversation

with a provider about important topics; contraception, sexually transmitted infections, and intimate partner violence. Most women report that they have talked to a provider recently about contraception but that’s not the case on other topics. Interestingly, women of color had higher rates of counseling on HIV and STIs and really discussions of domestic and dating violence across the board for all groups are just much lower than for other topics.

Many sexual health screening tests are also now covered as preventive services. Four in 10 women say that they have been screened for an STI in the past two years but I think what's interesting here is on the right hand side you see over half of those women were under the impression that it was a routine part of an exam, which we know it is not necessarily always the case, so the actual rate is likely lower. I think we also want to think about the interactions that are happening in provider settings and some of the information gaps that might be happening there and how we can bridge those.

Of course, family planning is an essential component of women's healthcare. Under the preventive services coverage I think we've all been hearing a lot about this, all FDA-approved contraceptives for women with a prescription are now covered without cost sharing. There's been a lot of research on this, there's a lot of discussion in the news as well. What we see here is that among reproductive-aged women who have been

sexually active in the past year, about half report that they're using—they or their partners are using at least one form of reversible method of contraception. About three in 10 say that they're either pregnant now or trying to become pregnant or may have had a sterilization procedure, they or their partners, and are not capable of becoming pregnant. Then what we also see here is that about one in five sexually active women who despite reporting that they do not want to become pregnant, are not using any form of contraception now.

There are a variety of choices that we have for contraceptive use. We asked women what they were using in the past year, they or their partners, and what we saw was that the largest percentage was that their partners were using male condoms. We also have a significant share that report they're using oral contraceptives or the pill. Some people do report that they're using more than one method. I think what's also interesting here is that we see a sizable share are using long-acting methods such as IUDs or implants. These have been considered to be among the most effective at preventing pregnancy but also historically have had more significant upfront costs, so seeing how this changes over time will also be really important.

It has now been 15 years since emergency contraceptive pills were approved by the FDA. We've had a lot of debates around access and availability of EC over the past decade.

What we see is that the vast majority of women report that they have heard of EC and relatively small share have actually used EC in the past year; certainly a little bit higher among women in their 20s.

At the time we did this survey the contraceptive coverage provision had been in effect for more than a year. Among reproductive-aged women who were using contraception in the past year and who had private insurance, more than a third said that their plan had covered the full cost of their birth control without any cost sharing required. About another four in 10 said their plans covered part of the costs, and about one in 10 said that their policies had not covered part of the costs. I think it's important to remember that there are a lot of things to consider here. Again, we had a high share of women saying that they were relying on male condoms, which are not subject to the ACA coverage requirement and also, that the details matter when it comes to this. This is an early look at this and also considering that we know while oral contraceptives for example are covered under the ACA requirement not necessarily every brand of the pill would be covered by every plan for example. There are formulary limitations and we also do have some women who are still in grandfathered plans that are not subject to the requirement yet.

Another component of the healthcare system that could shift as the ACA moves forward is where women get care. Here we're looking at where women receive their contraceptive care and most state that they receive their contraceptives at a doctors office but the profile is different for women of color and it's also different for low-income women who have much higher reliance on community health centers and family planning clinics, many of which are supported by the public federal Title X program as well as through Medicaid. Increasingly we know that the insurance profile of women is going to shift and as more women attain coverage, either through Medicaid or through private plans, I think it will be really important to monitor what affect that has on where women receive care, particularly with regard to provider networks and provider capacity.

Also I think it's really important for us to remember that not necessarily everyone will gain coverage or have coverage. Those who are undocumented do not qualify. Some who are low income will not be able to afford to obtain coverage so it's likely that many women will still be reliant on safety-net providers.

Finally, on the one hand today we're talking so much about the ACA, but I think it is also important to take a step back and also remember that not all women know about the law's details or how it affects them. For example we've been

thinking a lot in our office about preventive services but we see here is about six in 10 women do know that the law requires coverage of mammograms and pap tests but it's less so for some of the other requirements. For example, about a third of reproductive-aged women know that the law requires coverage of breastfeeding support for nursing moms so still a ways to go in order to get that word out broader.

I'm going to stop there. As I said there are a lot more details and topics covered in the full report. I hope this gives an overview of women's interaction with the healthcare system. Like I said, it's an important time for our system and also provides the springboard for our discussion with our panelists. Thank you. [Applause]

ALINA SALGANICOFF: Thank you, Usha, that was terrific and I think you were able to give us a very good flavor of what's in the survey. Clearly, I encourage you to take a look at the report. There is quite a bit more that’s in there that I think could inform us as we move forward. I'd actually just like to kick it over to the panel so that we can get their impressions of kind of what they took out of this; where the good news is, where we still need to do more work, so I'm going to kick it over now to Amy to get us started.

AMY ALLINA: Thank you. First, I really do want to thank the Kaiser Family Foundation for this data. It's incredibly valuable because it does, as I think both Alina and

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Usha said, it gives us some good evidence about the advances that we're starting to make but also some important evidence of areas where we still have work to do to make sure that this law delivers on its promise of affordable access to care. I'm really excited to see this data as well as to think forward about what we'll see in the coming years as this all changes.

I'm going to use my time to discuss the findings that hold particular interest for Raising Women's Voices given the work that we've been doing and that we're going to be doing to make sure that outreach about this and education about the law is designed to reach women and that enrollment procedures are working for women, that the policies of these federal and state Marketplaces are friendly to women, help women really get the plans that they need and that are right for them. Then of course our advocacy in the states that have yet to accept the federal funds that will allow them to expand eligibility for Medicaid.

Where I want to start is with the really good news here that we see about what's already happening for young women. Usha talked about this, almost half of women in the 18 to 25 age group are now insured under a parent's plan. That's really dramatic and I think the policy of allowing parents to keep a child on their plan until 26 likely deserves a lot of credit for what we've seen in other research showing that rates of un-insurance in that age group have dropped. There's measurably

more insurance in that age group and that’s great news. This is a group that was very badly hurt by the rising insurance rates and increasingly they were facing a job market where the jobs that were open to them, their first jobs, didn't offer insurance and didn't pay salaries that allowed them to buy insurance on the individual market. This is a really big shift. If they were lucky enough to get a job with insurance they were then locked into that job because they could not afford to leave the job and lose their insurance because they wouldn't be able to get it any other way.

What this policy means, if the national data plays out the way we've seen it play out in states that had previously adopted a similar policy we're going to see effects even beyond healthcare. We'll see effects on young women's earnings because when you're not locked into a job because of the insurance it offers, you can make a decision about your employment opportunities based on what's really best for you and in states that adopted the policy we did see young women's earnings go up. That has life-long consequences; where you start your salary can really affect the trajectory over your lifetime, so that’s exciting.

As Usha noted there are important implications here for confidentiality and very understandably young women using insurance for their first time don't know about insurance practices like EOBs and the issue of having your parents get a

notice when you've gone to receive family planning services or screening or treatment for a sexually transmitted infection or services for LGBT youth. It's something we need to make sure women know about but we also need to look at ways to protect the confidentiality of those sensitive services and there are a few states that are out front in developing model policies. We've seen California do it. I know Massachusetts, Washington, other states are exploring it. We need to really look at those models and figure out how we're protecting confidentiality of sensitive services.

One last point I want to make around this is just the option of being on a parent's policy is really mostly available to kids who's parents have insurance and are able to afford to keep a child – pay the extra cost of keeping another person on that plan. That's not everybody. Youth who are aging out of foster care do have an option to remain Medicaid-eligible until 26 so that's another piece of the puzzle, that they are going to be young people who are still facing some of the problems that I talked about earlier.

Then I want to talk about cost as a barrier to care and the coverage gaps, so there are quite a few interesting findings here in the survey. Usha noted some of them. The fact that the cost of the barrier is more true for women than men I think is not surprising but really there's good data there to help us understand it. Also not surprising that it's

more true for uninsured women but that cost is also clearly a barrier for women with insurance and that the cost is multi factorial. I thought that that slide that you put up that showed that across the economic spectrum, every woman says I've got trouble finding time to go get my healthcare needs met. Probably no one in this room is surprised by that but the economic pinch for healthcare isn't just about insurance costs or out-of-pocket cost sharing. It's also about the burden of the cost of missing work, the cost of childcare, the cost of transportation particularly when you look at the lower-income women. We need to think about that when we think about how to make sure everybody is getting the care that they need.

Also just the fact that low-income women and women of color are more likely to be uninsured and that low-income women experience more gaps in coverage, those things are also not surprising but given that, the decision by about half of the states to turn down the federal money that they could be using to close some of those coverage gaps by expanding eligibility for Medicaid is shameful. It's something we need to be working on. We're certainly trying to work with advocates in those states to hold policymakers accountable for the consequences of that decision and that may be the way to address this problem but until we get there we need to keep a focus on the people who are still left out and figure out ways to meet healthcare needs in the interim.

Then I would also just say that I thought the findings also give us an understanding that postponing or skipping care when you can't afford the cost is not a crazy decision. To understand that experience and the thoughts of that woman whose doing it, they're findings here that show that a significant percentage of women who incurred medical debt, again across the economic spectrum, reported that they had to use up most of their savings. They had trouble paying for food, for heat, for housing. They had to borrow money. They were contacted by collection agencies. These are also experiences with lifelong consequences so we need to keep that in our minds when we look at the decisions that low income and uninsured women are making.

The last area that I want to try to talk about quickly, because I know Vanessa will also discuss it, but I want to talk about preventive care and specifically contraceptive coverage. We're certainly aware going into this effort that cost was a barrier for women getting contraceptive care and that’s why we and many other women's health advocates worked so hard to make sure that the law required insurers to cover the full range of women's preventive services without cost sharing. Then worked hard again to make sure that the policy followed the evidence that our IOM allies, or colleagues, carefully compiled and discussed to show that contraceptive care should be included as a core preventive service for women.

I have mixed feelings about the finding that a third of women with private insurance are reporting that they get the full cost of their contraceptives covered because on the one hand I want to say it with a big smile on my face. We're hearing from women all the time that zero co-pay is really exciting to them. It's a provision of the law that they are thrilled by but we do know that women are encountering trouble getting that coverage from their insurers. The law and the regulations are pretty clear on this but they're having problems getting it done. I'm holding my biggest smiles for the day when we're much closer to 100. We're never going to get to 100 for some of the reasons that Usha pointed out. In addition to what you said, there are going to be some women who work for churches or Houses of Worship or arts and crafts supply stores [laughter] but we should be able to get a lot closer and I hope that that’s something we will see in the out years.

We need strong enforcement of this provision and we need it from HHS, we need it from state insurance officials and until it becomes the established norm, we need to educate women about what they're supposed to be getting so they can demand it, so that they can fight it when they get denials that they shouldn't be getting.

ALINA SALGANICOFF: Thank you. I'll kick it over now to Francisco.

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FRANCISCO GARCIA: Thank you, Alina, and thank you to the Kaiser Family Foundation. It's a real privilege for me to be here today. The perspective I bring to you is one that sees this report through the lens of a public health department, a local health entity. I come from Pima County, a jurisdiction about the size of the State of New Hampshire with about 1 million people, two tribal nations, and sharing a 300-mile border with the neighboring country of Mexico. That is a slightly different take and a slightly different set of challenges that we live in a very politically different world than we encounter here on the East Coast.

I think one of the things that is most impressive to me about this report is to my knowledge this is the first time that we're actually hearing women's voices on this issue immediately in the post-implementation of the ACA. There's been a lot of opinion and a lot of consumer feedback about how the ACA has rolled out and women's voices have been heard in that setting but in terms of actual utilization of services and offerings I think this is the first time that we're getting feedback from our consumers in very real and substantive ways about what it is that they are experiencing in the healthcare Marketplace.

This becomes then the benchmark by which we judge future progress in this area and make no mistake about it, we are still very early on in this process, and what we are seeing

now I hope is the tip of the iceberg. One of the conversations about the ACA has focused on the role of public health and health departments and what really is the existential challenges for those of us who deliver healthcare in those public settings. In fact, many have argued that we really don't need health departments anymore. We really don't need Title X clinics. We really don't need family planning clinics because those services and needs will be met through other providers, through private sector and public sector providers.

I think one of the things that this report reinforces, which has been borne out in the state of Massachusetts, has been borne out in other areas where implementation of health insurance reform has occurred is that there continues to be a very deep and important need for the provision of those public health services through these safety-net providers. Specifically, for poor women and women from communities of color, these entities – Title X clinics, public health departments, FQHCs - continue to be disproportionately over represented in terms of being able to reach and deliver these services to those populations. I think that’s a really critical piece here.

I don't think it's a number, a percentage that is going to decrease measurably over the next few years. It's not just because I want to keep myself employed but because I understand how consumers are actually accessing these services in the real

world. The report really sort of highlights how women in poverty and low-income women have special and unique challenges and have a different perception of their own health and their own ability and disability than other women. I think that that self-assessment is borne out of a recognition of the many life challenges that they're facing along with their health issues. It's important to understand that when we talk about access to care, when we talk about decreasing barriers to enter into the healthcare environment, we're not just talking about the co-pay, we're not just talking about actually having a Medicaid card, and by the way, in the state of Arizona we call it Access, is our Medicaid brand, it is about actually having the opportunity to use those benefits.

Make no mistake about it, there are opportunity costs that are associated with the utilization of those benefits. Opportunity costs in terms of childcare, in terms of flexibility of employers, in terms of the caretaking role that so many women of so many different ages serve in their families both formally and informally. In our jurisdiction we see very young women having to take care and responsibility for parents and for their siblings. Unless we can figure out how to decrease those barriers for those young women to come into care, I think we will have missed a tremendous opportunity.

What does that look like? Well, this is the place where I think the accessibility of services becomes really,

really critical and that’s why safety-net providers that are disbursed throughout the community that are well trusted within those communities become such an essential and integral part of the solution of how we improve care to those families.

I want to say also that one of the other things that Amy sort of brought up that is really important is for us to start thinking through what the privacy issues are, especially for young women who are covered under their parent's health plan. I think we're underestimating the chilling impact that the sort of mandatory disclosure and the explanation of benefits potentially can have to access to reproductive services. I think that in many cases we are barely beginning to even talk about it at the level of the states but that one of the things that we need to start thinking through is how to transform those administrative procedures, those administrative policies that will allow us to safeguard the privacy of young women and men who are seeking sensitive services because I think unless we can do that, again, here's another key piece where having a Medicaid card, having an insurance card doesn't necessarily guarantee that you're going to use those services.

If you are a young woman and you think your folks are going to find out about this and they're going to be angry or concerned or judgmental in any way, this is going to impact your ability to access those services. Again, this is part of the reason why safety-net providers, Title X clinics, family

planning clinics, local health departments, become such an important piece in the jigsaw puzzle that is the delivery of services to these folks.

Finally, I think I also want to sort of talk about who is in and who is out in terms of how we think about the Affordable Care Act and the impact of coverage for this country. Make no mistake about it, from my personal standpoint this remains probably the most important piece of legislation that will occur during my lifetime. The provision of access to such a tremendous proportion of our population just cannot be underplayed. However, as I've said before having access to an insurance card does not actually represent good health outcomes. It is but the first and most essential rung in climbing up that ladder of health and wellness. There are groups that are out and we need to acknowledge that and come up with safety nets for those groups. Who's out and what are the implications?

Mixed immigration status families, that is families where some of the family may be here illegally and in an undocumented fashion. We know that the uptake in Affordable Care Act participation is lower among those families. Folks who are uninsured—I'm sorry, folks who are unbanked, the unbanked, folks who have a hard time having access to the normal kind of banking mechanisms will continue to be left out. Women who are involved in the criminal justice—women and men

who are involved in the criminal justice system. We need to keep in mind those populations that continue to need special attention and we need to figure out how to get it done for them. I thank you for your attention. [Applause]

ALINA SALGANICOFF: Cara?

CARA JAMES: Thank you. Good morning, everyone. It's good to be back at the Kaiser Family Foundation.

ALINA SALGANICOFF: It's good to have you back.

CARA JAMES: I too want to start by thanking Usha, Alina, Adara, and Nisha for the work that they've done on this report. I know how much it takes to get some of these things done and the breadth and the depth of data that’s included in this report is really truly impressive and that is something that I know we, and I see a number of my federal colleagues here from the Office of Women's Health and also at CMS, will continue to be looking and delving through in the years to come before the next four-year report. We thank you for that.

I think a number of the findings that have already been touched on that I think are very interesting and the perspective that I bring to the conversation is both that of kind of our federal colleagues but also those that focus on a lot of the low-income and minority women who experience a lot of health challenges, some of which are documented in here and what we are sort of looking to do how and we can improve both

their access to coverage as well as the healthcare quality and health outcomes for these populations.

I think that as we look through here, we've already commented and a number of us that it's not surprising some of the challenges we see with regards to the logistical barriers and the costs and I love how Amy said that these were really multi-factorial issues that we have to address and in some ways thinking about because the theme that we have throughout this conversation is getting people coverage is a great first step but making sure that they understand and utilize their coverage and are able to be able to improve their health is really the critical next step and there are a lot of challenges that we have towards making that happen.

I think one of the other things that we have touched on a little bit and also is critically important is the role that the safety net plays particularly for low-income women and women of color. I think it was particularly interesting, as Usha was highlighting the safety-net role for contraceptive care but also when you look within the survey overall some of the issues and the role that the safety net plays. As we think about some of the other policy issues that are related to the ACA that we're not really talking about here that relate to the safety net there are implications for access to care as we move forward and need to be mindful of those as we continue on.

I think also that the report has a lot of opportunities and I'll ask- 'll put on the table is we keep mining the data because a lot of it is great that we have the data for race and ethnicity, for Hispanic women, and for African American women, and the income pieces and the way it's parsed out throughout the report. I'd really encourage my colleagues here to continue drilling down to be able to put out some more of those information's because I think some of the intersection that we see particularly for low-income women and women of color, but also looking at women who have chronic health conditions and in some of those, how their experience may differ can also lead us to a lot of opportunities for working to address these issues.

Also some of the differences in the coverage, which are highlighted throughout the report but continuing to spotlight some of those as we're moving forward because we do have different access points that are happening. We've already talked about some of the states that are not doing the Medicaid expansion. These do have a disproportionate impact on particularly African American and Latino women as we're moving forward and I think really we want to keep our eye on that as we are also working with those states to move forward.

In terms of the coverage and access we're coming on the heels of having more than 13 million Americans who've gotten coverage through the Marketplace or the Medicaid expansions and we see that, as we've highlighted in the report that four in 10

women have been able to stay on coverage through their parents, which is great. One of the things that we noticed in the report that I don't think was one of the things that was in the slides, but in the report we see a number of women are already connected to care and that's great. They have a usual source of care and quite a number of them have a regular provider. One of the things as we're thinking about educating the individuals who are getting coverage, the report also highlighted that 16-percent of the uninsured women surveyed are using the emergency room as their regular source of care.

As we think about getting them into appropriate care for utilizing the preventive services that we've talked about here to be able to maintain their health and have long and healthy lives that's an area where we're going to need to work on and I think helping people to understand how to use their coverage is very critical towards doing that.

One of the other things to note is that we've talked about the ACA is much more than the coverage expansion and we're talking about today the role that coverage has and also the preventive services, but the Affordable Care Act is also an opportunity to improve the quality of care that individuals are receiving and to improve population health. I think one of the things that the survey really highlights with regards to this is knowledge is power. Part of that is really helping people to understand what is included in the law. We see the survey

results about the lack of knowledge that we have across the board with regards to preventive services and the law has been on the books now for a number of years and we still have a long way to go about educating individuals about what the law is doing. Also now we really are shifting as we've gotten all of these millions of individuals into the healthcare system, we need to help them see the value of what they have just purchased because if we don't we're going to lose them when we come to the next enrollment period and also again, looking longer term in those healthcare costs.

I think when we look at the preventive services and you see that 60-percent of the women surveyed knew about the preventive services and the plans covering that, I think as we're looking across the life spectrum we also know that this is a challenge for our Medicare beneficiaries as well and our older women who also have access to a lot of preventive services are not utilizing those and I think a knowledge gap is also a critical part of that.

Women still are the center of their family and they can serve as that teacher to help educate their children and spouses in utilizing healthcare services and again the benefits of this. I think we really have a strong obligation and opportunity to really work with women to help educate them about what's happening so that they can share the knowledge. As you saw throughout the enrollment period we really relied

heavily on moms to help get their kids enrolled in coverage and I think, again, this is another role now that they've gotten the coverage how do we help connect them to care.

I wanted to take just a couple of minutes here to highlight some of the things that we are looking at within the federal family and again we have a number of colleagues here from the Office of Women's Health who have been working with us, working on these issues for a long time and it's just a sample of the many individuals throughout the federal family who care about these issues and are working to address them. In CMS in particular, one of my colleagues here, Marsha Lillie-Blanton has been working in Medicaid to make sure that we're improving maternal and infant health outcomes, really focusing on increasing by 10 percentage points the rate of post-partum visits among pregnant women. As we focused in the report on some of the reproductive and sexual health issues, those next steps when we're particularly looking at some of the unintended pregnancies and the consequences related to that of getting healthy children, healthy babies.

This also is focusing on increasing by 15 percentage points the most and moderately affective methods of contraception's in at least 20 states so taking some of these findings we'll be very interested to see how we're working to move that needle over the course of the process for this. Also, this is part of the larger effort that CMS has been doing

with regards to improving perinatal health outcomes and we have throughout the Affordable Care Act also created the Center for Medicare and Medicaid Innovation, which is working to improve health and quality and cost throughout a number of programs. One of the programs that they have is the Strong Start for Mothers and Newborns and that is working to reduce the number of early and elective deliveries that we're seeing throughout our system.

We also, our CMS Office of Minority Health is working to improve our data collection for race and ethnicity. We saw in the report and our colleagues acknowledged some of the challenges with reporting what's happening in the number of the other populations and part of that is a bit of a data issue and something we all know very well when we're doing disparities work and that’s something that we are working on.

I also wanted to just highlight as I close out an initiative that we really are looking at for those next steps. This is a project we like to call in our office the "so you got coverage, now what?" It really is providing those resources because when you think about as we see in the survey some of the challenges that the uninsured women have coming in, the lack of knowledge, we really have got to work on educating them about the benefits, helping them connect to the healthcare system so that they can begin to utilize it appropriately so that we see overall opportunities to improve their health so

that they're living long and healthy lives. We have some resources that we've been working on to develop that and they're sharing those, those are available through our website and are working to do a national launch of those as we've been piloting those since January in a couple of states including Pima County.

That's been something but I think again just to bring it back, this has been a really great survey and I thank our colleagues here for the wealth of data that they have provided and encourage you again to continue mining that and to help us look as we go across the next few years of how we can continue to improve the lives of all women throughout our country. Thank you. [Applause]

ALINA SALGANICOFF: Thank you, Cara, we are going to take probably a week off [laughter] from the survey before we delve back in and we are actually—we do have plans to do an initial analysis and work on the survey so there will be more new information coming out from the survey as well so this is just kind of the first look. Now, I'd like to turn it over to Dr. Vanessa Cullins.

VANESSA CULLINS: I thank Alina and Usha and the rest of the team for inviting me to be a part of this panel. I really thank you all for your forethought in putting this particular survey together and on your plans to repeat the

survey prospectively so that we'll have some comparative data over the course of time as the ACA is actually implemented.

This is such an important law but it is only incremental change towards a public health oriented system in this country. It is so very complicated because of states' rights issues and because the Supreme Court is allowing states to decide whether to expand Medicaid. We definitely are going to need to be able to make comparisons over time, to make determinations as to what is really working and why. In addition, there is a great deal of change that’s going to need to occur in order for us to achieve the intentions of the ACA Act, which is to have affordable healthcare, to have quality healthcare that improves clinical outcomes not only for individuals, but also for communities, for populations.

This is very, very different from the way medical care has been evaluated and thought of in this country so there's a difference in mindset that needs to occur across our entire population, not just with consumers but also, and more importantly with providers and also insurers with the payers. The payers have always been very non-transparent on a number of different levels and from the standpoint of consumers it usually is manifested in not really knowing exactly what's in your benefit policy until you need some form of care. The importance of the ACA is that it at least establishes a floor of benefits that should be offered to everyone. As was

mentioned by the other panelists, it's going to take enforcement and diligence from all of us in order to uncover whether or not the plans are really covering exactly what they're supposed to be covering.

In this particular study I was both encouraged and discouraged by some of the findings. One of the issues that I thought was very important to note was that many women incorrectly believed that STI tests are part of a routine examination. If you pair that with the data that many providers don't do the tests that they're supposed to be doing such as annual Chlamydia tests for all women under the age of 25, or determining whether or not baby boomers have hepatitis C, when you pair those things together then we have a lot to do in terms of consumer knowledge and also provider knowledge and it's going to take advocacy on behalf of ourselves and also on behalf of our families in order to get to what the ACA promises.

It's going to take time. It's going to take generations but we can get there as long as we prevent the political process from derailing it. We will need to continue to tell the stories of people who have benefited from having better insurance or insurance for the first time for themselves and for their families. For me, ACA is extremely important because of the focus on the family and on the community and also the focus on preventive healthcare.

In terms of preventive healthcare, what is preventive healthcare? Well, we have a number of essential benefits that speak to preventive healthcare yet many providers, healthcare providers, are at a loss as to what should be included in a preventive healthcare visit. Traditionally, family medicine, Ob-Gyn somewhat, pediatricians, have been the main physician side of providers that have dealt in the arena of preventive healthcare. Yet, that preventive healthcare tends to be fragmented and in fact, I was honored to be part of the ACOG Well-Woman Task Force, which met earlier this year to look at the IOM recommendations for preventive healthcare, US Preventative Services Task Force, and the recommendations for preventive healthcare and then also guidelines from all the professional societies.

The experience was a really great one. We still needed to look closely at those guidelines to determine which things were evidence-based versus expert opinion and then to give recommendations as to what should be part of the well-woman visit. Now when you finish with that exercise, which was divided into age groups, we came up with many different assessments in screenings that need to be provided. You're talking about screening for substance abuse. You're talking about obesity, underweight, nutrition, safety, intimate partner violence, which was discussed, depression. There is a long list of what should really be done to provide preventive

healthcare such that I was happy that written into the law is that you can have at least one well-woman visit each year, it’s at least one.

The mindset of providers has been one, providers that I talked to, but I want people to begin to think about it as preventive healthcare over time. Some women may need two or three well-woman visits during the course of the year but everybody needs at least one. This is a change in mindset and also a change in behavior that is going to need to happen over the course of years if indeed we're going to implement the ACA as it is intended. The issues in terms of the logistical problems, which post barriers to healthcare is an example of those other determinants of health that the ACA cannot address but needs to be addressed through our political process. Such things as income inequity. Such things as paid leave, personal days that are paid, sick time that is paid, companies really giving you time off according to the Family Medical Leave Act, if you and your family so qualify.

To wrap things up, we're at a good point in time in history but we're going to have to be vigilant and we're going to have to push in order to make the changes that are intended through ACA. [applause]

ALINA SALGANICOFF: Thank you. You've all raised, I think, some really important issues about really the need for public education both in terms of letting people know how to

use their service, how to enroll. We've had a big discussion nationally about enrollment. Everybody's breathing for a little bit and now preparing for the next round and now as Cara mentioned really kind of, what do we do with our insurance card in terms of informing consumers.

I think that there is also a really big role here. We heard about the safety net. I think the role of clinicians and I think that's really important. I think we don't have—there's a lot that's covered there in preventive care. We had a lot of discussions at the IOM committee about, and I don't know if you've looked at the report, but there's a lot of services that could be potentially considered for a well-women care. We're also moving to a place in medicine where care is very personalized. How do we make sure that we personalize care at the same time we make sure that we do provide services to patients based on evidence-based standards of care and really assure that women get quality of care.

We also hear that there's a lot of different challenges for women. There are some universal challenges but particularly low-income women, uninsured women, and we're still going to have many of those gain access to care and how do we make changes and think about how we make changes to the larger system. Healthcare does not operate in isolation. We talk a lot about healthcare costs. They don't operate in isolation

either and in terms of how we use systems. We need to really consider the larger context of women's care.

I think the other issue that has come out is the important role of the safety net. There are still going to be people that are going to be falling through the cracks, both people with insurance cards now and there are going to be a lot more of those in terms of Medicaid and private insurance but also women who are not going to have a pathway to coverage but who are still going to need healthcare services. I think that that's really something that I think comes out loud and clear.

I want to just pose, before I open it to the audience, I did just want to pose one more question. We talked a bit about the next survey we're going to do, but we've been doing this survey since 2001 and I have to say that one of the things that I've really been struck by is the consistency of the findings and the lack of change. There's a little bit in there, some things have changed but a lot of these are really persistent challenges that women face both in terms of cost, in terms of access, how they use care. The ACA has made and will make a lot of changes but I guess I wonder kind of looking forward to the next survey, what do you think are going to be the big things that we're going to be talking about? What are the big findings that you think we're going to have in another four years and where are some of the levers that we need to focus to get to that?

Amy, I'm going to ask you to talk about coverage, Francisco, to talk about maybe the safety net and the preventive services and public health, Cara, you can talk about disparities in terms of what you hope to find or what you realistically might expect to find, and Vanessa, in terms of how clinical care might change.

AMY ALLINA: I'll start by agreeing with something you said that's sort of on the pessimistic side. I think we will continue to see gaps. This law is not going to get us to universal coverage. There are people left out and I don't expect that in four years we will have made all of the policy changes necessary to cover those gaps. I wish I was saying something more positive there but I do expect that finding and that that will be something we will be continuing to talk about. I'll give one more optimistic prediction—

ALINA SALGANICOFF: Optimism is okay. [laughter]

AMY ALLINA: Yes, I'd like to be in that space. I do think that we'll see—I was talking about how with full, contraceptive coverage without costs of it being one in three- I think we'll see that grow in the next four years. The survey was done at a point when we were just a year into that and there were still women in other plans, that'll shrink I think because of the high level of interest and excitement in that provision of the law. We're going to see more and more women knowing about it and getting what they need. I hope we will

also see insurance plans figuring out that they really do need to comply with the law. There may be some work to make that happen but I know that that work is underway so I have some optimism there although I should acknowledge that what we hear from the Supreme Court at the end of June could have an affect on whether we see progress in that area.

FRANCISCO GARCIA: I have to sort of share your pessimism in terms of some of the coverage gaps that we will continue to see. I think that the political wherewithal to really get to a place where we can achieve full insurance coverage is just not necessarily there. That being said, I think that safety net providers in specifically health departments, family planning clinics, will continue to see a shrinking number of resources because whether rightly or wrongly the perception from the policymaker standpoint, from my political bosses, from legislators, from governors, is that the Affordable Care Act should decrease the amount of demand for those services on the public health side. As we've seen in Massachusetts, as we've seen in a variety of different settings, that’s just not necessarily the case.

I anticipate that I will continue to be having some relatively tough conversations with both our federal and our local level funders about why safety net services continue to be needed and why those systems need to continue to be reinforced. From the consumer end of things, I think that we

have a powerful brand in public health and in family planning that really speaks to the quality of the services that we've been able to offer, the high-level of confidentiality of the services that we offer our clients. That is going to be, I think, something that will be challenging for some of our clinical colleagues in other settings to be able to achieve the same sorts of expectations. I think that that's one of the things where I hope that consumers really drive this because I think women want that.

I know that if women speak to their providers, their insurance companies, and demand a certain modicum of privacy and confidentiality with regards to sensitive services that we're delivering, whether it's STI or contraception, or in the cases of other services, I think that that's going to be really essential. I always say that women are a hell of a lot smarter as consumers than anybody is as a policymaker and that ultimately the interaction that they have with their providers, their insurance companies, their state Medicaid agencies, I think will be really salutatory as we look forward.

CARA JAMES: With regards to disparities, I think a lot of it is going to be contingent. I think one thing I'll put out there optimistically that in four years we'll have another racial and ethnic category in their survey that we can look at so we'll have more information on that. I know that you had Asian Americans included in there but not quite enough to

report so I'm hopeful that in four years that'll be something we can look at.

I think as we think the coverage expansion we started open enrollment with basically 40 million people who are uninsured and we picked up a number of them but we still have a number left. Many of those, I think, when we started a number of them disproportionately in communities of color and we have a large missing percentage of the enrollment data on race and ethnicity but we still know we have some challenges within that population, these populations of getting them covered. The first step is hopefully that in four years we will see a lot smaller number in terms of those who are uninsured but I think as all of our panel, as Amy and Francisco has said, we'll probably still see some gaps.

I think one of the other things is the extent to which we can work in those other states to get them on board with Medicaid because the interplay between race and income is huge and a number of those communities of color who are uninsured are disproportionately low income and if those states don't come onboard I think the cost barriers that we've seen in the report will continue to be there.

I think education; people have got to see what they're getting and understand how to use it. I think it's great that you see women who are learning about some of the preventive services that are covered and I think we will continue to see

that tick-up. Then with that, I think the corresponding utilization rates will tick-up so that we will see decreases in disparities in those preventive service utilization but I think a lot of it is kind of contingent on how we continue to connect with our individuals.

Then the actual provider side of the equation I think is still a critical piece of this that is a little bit unknown at this point as to what happens with regards to access to care as we have more people who are coming into the system trying to get them to utilize it appropriate and stick with it is going to be important. I'm hopeful but I think we still have some work to do.

ALINA SALGANICOFF: Guardedly optimistic?

CARA JAMES: Guardedly optimistic.

VANESSA CULLINS: In four years, I'm hoping that the slide among women with private insurance, one in three report the plan paid the full course of contraceptives will increase substantially because the private insurance should also include the exchanges. Hopefully more women will have the opportunity to get their contraception that they want with no co-pay and hopefully we'll see more women that are choosing long-acting forms of contraception, less women that are choosing oral contraceptives, which have been marketed heavily in the past but have very low continuation rates.

I do think that we will see an increase in women's knowledge about ACA coverage for preventive services; at least I hope that that is going to be the case. I'm also hoping that women and men will have a better sense of how to utilize insurance and how to really access the preventive healthcare and how to choose the best coverage for them and their families and to base it on more than just the premium cost or the co-pays and deductibles and that we have within the exchanges more people that are going to be choosing Silver plans on up, Silver, Gold, and Platinum and not Bronze so that they can take advantage of the tax subsidies.

ALINA SALGANICOFF: Usha.

USHA RANJI: I guess four years down the road I expect that, as I said before, the insurance profile will change. I hope that we, this is more a hope, I hope that we do work towards some of the points that have been raised around being able to better know and be more clear about what is covered in plans, particularly we have many new plans now in the market. That’s also going to be changing a bit over the next few years as the Marketplace is developed but I hope that part of that process is also being able to get at a little bit more around so that when women are making the choices as you just said they are able to do that with some more information than just the cost, which is obviously a huge part of it.

As we said before, we don't always know what we need until it comes up and so being able to be more explicit about that up front I hope that a new Marketplace can provide that opportunity as well.

FRANCISCO GARCIA: One of the things that the whole ACA discussion and enrollment piece has really made obvious is that our concepts of health literacy are probably really limited. That we specifically with regards to ACA that we really are talking about insurance literacy and that's how we framed it in our jurisdiction. I think that—and we've been doing lots of communications and lots of trainings around that with our consumers and I'm hoping that everybody's level of knowledge and sophistication on insurance and insurance-related issues is actually going to improve. Not just folks who are new to the system but I think it's forced me to look at what those terms actually mean.

For heaven's sake, I've always had good coverage but I've actually never really understood what some of those terms meant. I think this is a place where this floats everybody's boat that we all become much more sophisticated users of the insurance product.

ALINA SALGANICOFF: Okay, thank you. I'd like to open it up to questions. We have Tiffany on the side there, Adara over here, and Katie, so Adara in the front row and you get kudos for that. [laughter]

PENNY STARR: Penny Starr with CNS News, you've alluded to this but I wanted to ask anyone who wants to answer more directly and that is there's reports that since the ACA has been in effect that actually the full range of contraceptives under the law is less accessible for women because some of the private plans are not offering the full range, they're only offering specific contraceptives. This is what's been reported.

Secondly, that because of the standards in the law that in some plans, not Medicaid of course, private plans that the costs are increasing.

AMY ALLINA: Do you want to start?

ALINA SALGANICOFF: Yes, I can start. We've been doing a lot of thinking around this. I think what you're referring to is that the law—first of all we can't tell that from this particular survey in terms of what's covered and what's not. As, I can't remember who said, a lot of times you find out what is included in your plan is when you find out you're not covered for it. It is difficult to sometimes understand that.

The law says that there are certain ways that women need to use the services in order to get no cost services. One, you need to be in a plan that’s not grandfathered, you need to be a network, and that you need to be offered the full range of methods. Now, is it going to be every single contraceptive pill? No, some of the plans also we've been

hearing don't cover the patch. Some don't cover the ring. There are issues, whether this is a systemic problem we really can't tell. We did ask, are you having problems? Most women say that they're not having problems getting their insurance but I think, again, we talked about how does insurance work. I think that this is an area that definitely merits a closer attention but we're not seeing, I think a systemic problem, but we are seeing isolated issues.

I don't know, Amy, if want to talk about that.

AMY ALLINA: I would just, picking off of one element of your question, I would be surprised if we're actually seeing a decrease. I think that the coverage practices of the insurance plans are probably pretty consistent and that what we're seeing right now is them trying to figure out from a business perspective how close to the edge of the law they can go. I say this in a lot of presentations that I do when I'm talking about the law that we didn't, as a country, make a decision to get rid of an insurance system and just say everybody gets the healthcare we need.

We could have made that—well, we probably couldn't have, but that was a decision that—that was an option and we didn't take it. We're still working within the context of a for-profit insurance industry and those for-profit companies are going to be figuring out how to work within the law. We need to push them to meet the terms of the law and to cover

every FDA-approved contraceptive method, which we know in some cases plans are not yet doing but I think we can get there because we have strong statute and strong regulations to work with.

VANESSA CULLINS: I'm going to take another tact and that is, each insurer is going to have their own formulary. The important thing is to have each class of contraceptive method on the formulary and obtainable without a co-pay. As Alina was saying, you're not going to have every single brand of an oral contraceptive but you should be seeing a patch, a ring, both IUDs because they are for different indications. You should see emergency contraception without any co-pay and it should be the best forms of emergency contraception, [inaudible] if you're talking about the pill and if you're talking the IUD, the copper IUD.

Again, one implant we only have really one implant now even though we've got different names for it. [Laughter] as one you can see on an x-ray and the other one you can't but you want one of each class of contraceptive methods. If you're not getting that, you find out that what you want is not being offered that’s when the screaming starts and we've got to figure out a system to work together to advocate for those things that we need in terms of healthcare especially preventive healthcare that are not really being provided by the insurer or the healthcare provider.

FEMALE SPEAKER: [Inaudible] cost.

VANESSA CULLINS: From the standpoint of the consumer it should be no cost, no extra cost. The issue is going to be the provider and where it's going to be stocked in inventory and the push from a provider standpoint because they're not going to necessarily be able to buy all the methods, is going to fall probably more on pharmacies and women are going to have to probably go to pharmacies to pick up their methods potentially and then bring it back for it to be inserted or administered.

I mean, there are going to be various mechanisms that people are going to be trying—people as insurers and providers, will be trying to employ and to experiment with in order to make this affordable on all sides of the equation, whether you're talking about the provider cost, the insurers cost, and most importantly from my standpoint the consumer cost. Those things that are not there to the consumer definitely need to be uncovered.

ALINA SALGANICOFF: The cost doesn't go away. The cost issue to the insurers, to the providers, as well and I think that the stocking issue is definitely an issue that’s come up where particularly the IUDs they have high upfront costs and so how women are going to get those and whether we can provide these rather than requiring multiple visits to really take advantage of the opportunities that the law offers I think is

something that is going to take some work and attention. In the back now; we went to the front and now we go to the back.

REBECCA ADAMS: Hi, it's Rebecca Adams with CQ and I have one quick question and one longer question. I was interested in the statistics that 45-percent of young women are getting their coverage through their parent's plans and Commonwealth had something similar, they found 51-percent of men and women are getting their coverage that way. What can you tell us about how those young people got their coverage before the ACA and what is the number of individuals who are on their parent's plans? That’s the quick question.

Secondly, I was hoping Cara could tell us more about what you're going to be doing with your outreach campaign, the “now you're covered, so what.” Tell me a little bit more about what you're planning to do and how much money you're putting into it and what we should expect from that if you don't mind.

USHA RANJI: I can take the first one there; we do not have necessarily before and after comparison data from this survey for the coverage numbers. We know that that number is an increase and I can work out the exact number but what we also do know is that before—that for many years this was actually the age group that had a very high uninsured rate and that we have seen a drop. I don't have exactly before and after specifically around parental coverage but we have seen a

corresponding and we have also seen a drop in the uninsured for this group.

ALINA SALGANICOFF: In the past really what we asked is dependent coverage. It didn't really matter before to the same extent especially for this age group because it was a very small amount of them were actually on their parent's plan but for this particular survey we changed the question so that we could distinguish between coverage as a dependent under your parent's plan and the coverage as a spouse, which is some of the cases as well.

CARA JAMES: To your second question about what we're doing, so for the past year we have been working in about four communities to understand what the needs are for the individuals who are likely to be newly insured and those coming into Medicaid. From that feedback that we received from consumers, providers, community partners, some payers and even some of the states that we've talked to, we developed what we call our roadmap. It has seven steps to help the newly insured understand the importance of using their coverage to stay healthy.

As we saw in the survey a number of women are not getting preventive services particularly those who are uninsured and part of that is a cost issue. I think the newly insured understand very much the importance of having coverage

when you get sick but not necessarily how coverage can be useful to stay healthy. That's one of the steps that's there.

We also have in the roadmap information specifically about an example of an insurance card so people can as we talk about the insurance literacy become familiar with the particular terms that they need to know and provide them with information on how to find a primary care provider, checking within their network and to make sure that they are having individuals who are there checking with other resources as well.

Then stepping through how to make that appointment, what they would expected to provide in terms of information, having both the insurance information, letting the office know that they're a new patient and so forth, being prepared for the visit and follow-up, so forth and also the last piece of making sure that they are engaging in a long-term relationship with that provider that they're meeting their needs.

We currently are testing that, as I mentioned, in about four states and are finalizing our plans for national expansion so I would say that you would be seeing a lot more coming up this summer as we're reaching out with our federal family to tap into a lot of existing networks that we've utilized. We've been piloting this with our sisters as well as other community-based organizations across the spectrum, not just in the health services that some other organizations like Head Start and

other social services to really meet people where they are. We'll be having a lot more coming forward with that as well as some of the video components that we've designed and it's currently available in English and Spanish and are looking to translate more as we roll out for more effort. The short of it is stay tuned.

ALINA SALGANICOFF: Other languages?

CARA JAMES: Other languages, yes. [laughter]

ALINA SALGANICOFF: I think we have time for one more question, Tiffany.

CLARA RITGER: Thank you, hi, Clara Ritger from National Journal. I was hoping you guys could go back to the health literacy discussion; health literacy has traditionally been very low among Americans and particularly with the low income and minority population. How much of that needle can we really move and in what ways or what programs are we going to be seeing in the coming years to get people to understand what's covered by the Affordable Care Act given just what we know already about how health literacy is low. We know that they don't know about the new benefits and coverage under the Affordable Care Act and there's really an opportunity cost to learning more about insurance and learning more about healthcare services.

FRANCISCO GARCIA: It's a really good question because I think that this was actually one of the areas that was

unanticipated to be a challenge as we had communications about what ACA meant and what our rights and responsibilities were under the Affordable Care Act. I really believe that we did not have that in folk's brains as the programs were being crafted and I certainly can't speak for the feds but I just have a hard time imagining that that was part of the conversation that was had. The emphasis really was on how do we bring people into coverage as quickly and as efficiently as possible.

I think that there was some under-appreciation of the complexity of the task. You're absolutely right to distinguish health literacy from insurance literacy. They're related but not identical concepts and we know that health literacy varies a lot specifically for linguistic minorities, specifically for low income folks, reading a label on a pill bottle or on the back of a food item that they buy at the grocery store can be a real challenge.

You add that then to terms like, what is a premium? What are covered benefits? That adds a whole other layer of complexity. Folks locally in the southwest are working on both the linguistic part, i.e., how do you translate these concepts to languages other than English conceptually as well as literally? Also, how do you start having smart conversations with low income folk about what these concepts mean?

One of the big fears that I have is that folks who are coming into the federal Marketplace especially at the margin of income eligibility are going to be churning in and out of the system, are going to be able to pay their premium for a couple of months and then drop out. It's particularly important I think for us who are in the public health arena to be able to communicate to them what the value of that coverage is and what the importance of that coverage is and what they're actually buying so that as much as we can, we can try to keep them in the system.

I know that’s not a very direct response to your question but the honest truth is we don't know.

AMY ALLINA: Just really quickly, I think this actually is an issue that advocates might have been attuned to first because trying to mobilize people in support of this law when they had no idea what insurance was became a real challenge for us.

One of the other core organizations leading the Raising Women's Voices initiative is the Black Women's Health Imperative and I wanted to just let people know that in addition to what Cara spoke about that starting before the next enrollment period, the imperative working with Raising Women's Voices is going to be doing a specific health insurance literacy campaign so that’s another piece that will be out there. It's badly needed.

VANESSA CULLINS: I just want to add that it's going to require a multifaceted approach and it's going to be multifaceted over time. It's going to be social media. It's going to be websites. For example, Planned Parenthood has a special website that is PlannedParenthoodHealthInsuranceFacts.org to specifically deal with what the ACA means and its issues around both insurance literacy and also issues around health literacy.

I think we're going to eventually over time, at least I hope, eventually over time families in communities will begin to routinely teach each other and talk about insurance because typically I know in my community and also in family even though we have health providers in my family we didn't typically talk about insurance and insurance coverage. Often times you have friends and family that are uninsured or under insured and you don't even know.

One of the things that’s I think going to move the needle is when we begin to have some honest dialogue in our families and in our communities about health and how to use the healthcare system to become healthy or stay healthy.

ALINA SALGANICOFF: I think we're out of time unfortunately. I do want to add to that point that when we talk about the decisions and the literacy, women are at the center of that for their own care and for their family's care,

their kids, their spouses, and their parents so that that is really an important target.

I would really like to thank you all for coming here today. I especially want to thank the panelists. I think we've had a really rich and textured discussion about both the opportunities that the ACA provides as well as many of the challenges that we're going to all face in improving access to high-quality care. I think the law provides a really important new framework for expanding coverage to the uninsured as well as setting the change to hopefully improving care for everyone. As we know, this isn't an easy stuff and it would be really nice to wave our magic wand and change the system but we know that we can't do that and it doesn't happen overnight. It's not easy that we're going to have women and health providers, plans, public health departments; everybody's going to really need to step-up if we're going to try to make the most and improve care for women.

I thank you very much for coming today. It's been a great discussion. [applause]

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.