

The Affordable Care Act and Women's Health: Improved Access to Preventive Services

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According to the Henry J. Kaiser Family Foundation, “Among the 96 million women ages 18 to 64, most have some form of coverage. However, the patchwork of different private sector and publicly-funded programs in the U.S. leaves one in five women uninsured.”¹ National survey data from 2008-2010, show that 13% of women in the US had an unmet need (i.e., delayed care or did not obtain care) for health care.² Those most affected were uninsured and poor. However, unmet need was reported even among women with insurance and those whose household incomes were more than 400% of the federal poverty level.²

The Affordable Care Act (ACA) has the potential to expand coverage for millions of currently uninsured women as well as stabilize and expand coverage of those current insured. Most of the provisions of the ACA will affect women and men equally, but the following highlight some of the access and coverage components of the ACA that could reduce unmet need and improve health outcomes for women specifically.

A. Expanded Access to Insurance

Women are disproportionately affected by insurance loss through divorce and switching from full- to part-time employment. According to data from the March 2012 Current Population Survey, women are less likely to receive insurance through their own employment (34% vs. 45% for men) and more likely to be covered as a dependent (23% vs. 14% for men).¹ **Further, in 2012, 20% of women 18-64 years of age in the US were uninsured and likely did not qualify for Medicaid or have access to employer-based plans.**¹ The ACA will address the insurance needs of women through:

1. Medicaid expansion. Prior to the ACA, only low-income women who were pregnant, mothers of children younger than 18 years, or disabled typically qualified for Medicaid (state rules varied). Medicaid expansion will eliminate categorical criteria (i.e., maternity, disability) and extend coverage to **all** individuals below 138% of the federal poverty level. Some states will extend coverage to those above this level of poverty. Kenney, et al. estimated that, if every state opted into Medicaid expansion (this has not happened), about 7 million women could gain insurance access through the Medicaid expansion and about 2.5 million of them would be 45-64 years old.³

2. Elimination of sex discrimination in premiums and eligibility. Many insurers have charged women up to 50% more than men for the same insurance plans. A 2012 report of national health plans showed that, in the 33 states that had not banned or limited “gender rating,” 92% of the best-selling insurance plans (only 3% of which included maternity care coverage) were more expensive for 40-year-old women than 40-year-old men.⁴ The report further estimated that **US women consumers paid more than \$1 billion/year more than men for health care insurance**, not including their expenses related to excluded maternity care coverage.⁴ The ACA requires that insurers stop gender rating in 2014: premiums for women and men must be the same.

3. Elimination of pre-existing condition clauses. Women have been disproportionately affected by pre-existing eligibility clauses to health insurance. While there is variation among states, some individual health insurance carriers consider pregnancy a pre-existing condition. In 2014, insurers cannot refuse to cover women who have had breast cancer, cesarean deliveries, or any pre-existing condition.

B. Expanded Insurance Coverage

1. Coverage for maternity care. In 2012, only nine states required insurers to provide maternity care coverage, but even in those states coverage may have been less than comprehensive and not affordable.⁴ Most

women with employer-based health insurance receive maternity benefits because of state and federal anti-discrimination protections, but there are generally no such protections in the individual insurance market (about 12% of such plans included maternity care in 2012).⁴ In 2014, all plans sold inside the health insurance exchanges—and all new plans sold outside of the exchanges—will be required to cover maternity and newborn care as an Essential Health Benefit.

2. No co-pays for preventive care. Starting in 2011, all new insurance plans must cover key prevention services, like contraception, well-woman exams (more than one visit/year if needed), and breast and cervical cancer screenings. In 2014, the ACA requires that new private plans cover even more preventive services and vaccines recommended by federally sponsored committees (“essential benefits”) without co-pays or other cost sharing, including bone density tests, the HPV vaccine, annual STI screening, and screening for domestic violence. Women may also receive genetic testing and counseling about the breast cancer susceptibility gene (BRCA).

3. Coverage for contraceptives. All Food and Drug Administration-approved contraceptive methods (i.e., plans cannot exclude any FDA-approved contraceptive), sterilization procedures, education, counseling and management services about contraceptive methods have been covered since 2012. *Contraceptive services for men (e.g., condoms, vasectomies) are not covered under the ACA.*

4. Expanded coverage for senior women. As enumerated in a report by the National Partnership for Women and Families,⁵ the ACA expands coverage for senior women (and men) by:

a. Filling gaps in Medicare coverage. Before the ACA, Medicare did not cover annual wellness visits or some preventive services (e.g., mammograms, cervical cancer screening, bone density tests). In 2011, the ACA assured that all Medicare beneficiaries became eligible for such services without co-pays.

b. Closing Medicare’s “donut hole”. As described by the National Partnership for Women and Families,⁵ the “donut hole” refers to the following provision of the Medicare Part D benefit: Medicare beneficiaries paid 25% of the cost of their prescription drugs (after paying their deductible) and Medicare covered the remaining 75% until the annual costs reached \$2,840. At this point—the “donut hole”—Medicare paid nothing and beneficiaries paid the full cost of prescriptions until they paid \$4,700 out of pocket. After they reach this “catastrophic cap” their prescription drug costs went down. It is estimated that 16% of Medicare beneficiaries reached this point every year—with women most likely to do so.⁶

In 2011, the ACA started to close the “donut hole” by reducing the cost of brand-name drugs for Medicare beneficiaries. It was estimated by the US Department of Health and Human Services that 2.05 million women saved \$1.2 billion on their prescription drugs in the first year.⁶ By 2020, the “donut hole” will close: beneficiaries will have to cover 25% of prescription drug costs until the “catastrophic cap” is reached. After it is, they will pay 5% of drug costs.⁵

c. Improving health services delivery. Many of the funded initiatives of the ACA are designed to specifically help individuals with chronic diseases and seniors, including:

- The ACA created the Center for Medicare & Medicaid Innovation to test, evaluate and rapidly expand new care delivery models that improve quality and care coordination. Such models include Patient-Centered Medical Home and a Medicare-shared Savings Program that provides incentives for health care providers to coordinate treatment of an individual across care settings.
- The ACA provides funds to hospitals and community-based groups to provide transitional care to high-risk Medicare beneficiaries (e.g., funds to reduce re-hospitalizations).
- The Geriatric Education Centers are important for women who are both caregivers and recipients, as they provide “...support training in geriatrics, chronic care management, and long-term care for family caregivers, as well as health professionals and direct care workers.”⁵

- The ACA also provides bonuses to primary care providers, include those in geriatrics

C. Conclusion

Through the elimination of discriminatory practices, extended coverage, and health systems reform, the ACA has the potential to improve the health of women of all ages and all income levels. Despite anticipated gains in women's health, there will likely be continued disparities related to variations in state decisions to expand Medicaid and in their mandates about benefits that must be covered by insurers; logistical issues; key stakeholder opposition to reproductive health service coverage; and the legislative—and unresolved—battles about specific ACA provisions.⁷

FOR MORE INFORMATION

- The National Women's Law Center has many up-to-date factsheets about women and the Affordable Care Act at: <http://www.nwlc.org/our-issues/health-care-%2526-reproductive-rights/health-care-reform>.
- The National Partnership for Women and Families has several resources about the Affordable Care Act at: http://www.nationalpartnership.org/site/PageServer?pagename=issues_health_reform_anniversary

REFERENCES

- ¹ Henry J. Kaiser Family Foundation. Women's health insurance coverage. October 2012. Available at: <http://kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/>
- ² U.S. Department of Health and Human Services, Health Resources and Services Administration. Women's Health USA. Rockville, Maryland: U.S. Department of Health and Human Services, 2013. Available at: <http://www.mchb.hrsa.gov/whusa12/more/downloads/pdf/whusa12.pdf>.
- ³ Kenney GM, Zuckerman S, Dubay L, et al. Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage? August 2012. Available at: <http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf>.
- ⁴ Garrett D. Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act. National Women's Law Center, March 2012. Available at: http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf.
- ⁵ National Partnership for Women and Families. Why the Affordable Care Act matters for women: improving health care for older women. March 2012. Available at: http://go.nationalpartnership.org/site/DocServer/OLDER_WOMEN.pdf?docID=10004.
- ⁶ US Department of Health and Human Services. The Affordable Care Act: strengthening Medicare in 2011. Available at: <http://www.cms.gov/apps/files/Medicarereport2011.pdf>.
- ⁷ Sonfield A, Pollack HA. The Affordable Care Act and reproductive health: potential gains and serious challenges. *J Health Politics Policy & Law* 2013; 38(2): 373-391.

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