Why the Affordable Care Act Matters for Women: Improving Health Care for Women of Color

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The Affordable Care Act (ACA) is the greatest advance for women's health in a generation, and women of color have much to gain under the ACA. By making private insurance more affordable, expanding Medicaid, creating new standards for providing culturally appropriate care, and supporting important care-delivery and system reforms, the ACA is helping to improve access to more affordable health coverage for all women and decrease health disparities that disproportionately harm women of color.

Expanding and Improving Medicaid

Medicaid provides essential care for women throughout their lives, from family planning and maternal health services to nursing home care. Women make up a majority of the Medicaid population[1] and many of these women are women of color.[2]

The ACA allows states to expand their Medicaid programs to close gaping holes in the nation's safety net.

- Under the ACA, states are encouraged to expand eligibility for their Medicaid programs to include individuals with household incomes up to 138 percent[3] of the Federal Poverty Level (FPL). Unfortunately, not all states have chosen to expand their Medicaid programs, leaving millions of otherwise eligible women and families without affordable coverage options.
- In 2015, in states that have expanded their Medicaid programs, an individual earning up to $16,243 annually qualifies for Medicaid, as does a family of four with an annual income of up to $33,465.[4]

Making Coverage More Affordable

When shopping in the health insurance marketplace, women can compare health insurance plans and find the one that best meets their health care needs and budget. The health insurance marketplace is a one-stop-shop that lets women compare health plans based on price, benefits, quality and other key features. All insurance plans offered in the marketplace must be designated as qualified health plans (QHPs), which means they must cover a set of minimum essential health benefits, comply with limits on cost-sharing

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(including limits on out-of-pocket costs) for these benefits, and meet all applicable private-market reforms specified in the ACA.

Premium and cost-sharing subsidies are now available to help make coverage more affordable. For women and families who don't qualify for Medicaid coverage, premium subsidies and cost-sharing assistance may be available to help make private coverage more affordable. Women and families earning between 100 and 400 percent FPL (up to $47,080 for an individual and $97,000 for a family of four[5]) may be eligible for subsidies that reduce the cost of their monthly health-insurance premiums. Individuals or families with incomes between 100 and 250 percent FPL (up to $29,425 for an individual and $60,625 for a family of four[6]) may be eligible for cost-sharing subsidies to reduce their out-of-pocket health care costs. Eligible individuals or families must enroll in a Silver-level plan to receive cost-sharing subsidies.

Women can no longer be charged more than men for health insurance. The ACA prohibits plans in the individual and small group markets from charging women higher premiums just because they are female. This means women must be charged the same amount as men for the same health insurance plan.

Women can no longer be denied coverage because they are sick or have pre-existing conditions. The ACA has ended outrageous, predatory practices that allowed insurers to refuse to cover women who had breast cancer or C-sections, who received medical treatment due to domestic violence, or who have chronic conditions like high blood pressure or diabetes. In addition, women with chronic illnesses no longer face annual dollar-value caps or lifetime caps on most benefits, enabling them to receive the care they need when they need it.[7] This provision is especially important to communities with higher rates of chronic illness; for example, people with Asian and Pacific Islander ancestry experience higher rates of breast, cervical, liver and stomach cancers.[8]

Decreasing Health Disparities

Women of color sometimes have unique health needs and suffer from higher rates of certain illnesses and diseases, including diabetes, heart disease, obesity, some forms of cancer and hypertension.[9] The ACA tries to address and reduce these health disparities.

Increased access to preventive care can help reduce health disparities. For example, African American women have higher mortality rates from breast cancer than white women.[10] Receiving preventive care earlier and more often could help African American women get diagnosed and treated sooner. Under the ACA, many preventive services, including mammograms, are covered with no cost-sharing.[11] African American and Latina women account for more than 80 percent of women living with HIV,[12] and under the ACA, women of color benefit from no-cost screening and counseling for HIV and other sexually transmitted infections.[13]

Greater access to preventive care for communities of color could decrease health disparities. Under the ACA, many preventive services, including mammograms, are covered with no cost-sharing.

No-cost family planning care gives women the opportunity to decide for themselves if and when to have children. Timely access to contraceptive services can improve maternal and child health by providing women with essential services to plan their pregnancies. With no copay for FDA-approved contraceptives, the ACA has helped reduced disparities in access to family planning care. Most insured women are now able to access many forms of contraception without cost-sharing.[14]

Better tracking of health disparities will help improve health outcomes. Data collection systems that measure health disparities need to keep pace with our country's rapidly changing demographics. The ACA orders the U.S. Department of Health and Human Services (HHS) to define data collection categories by race, ethnicity, sex, disability and primary language. With this change and others, HHS will be able to better determine what health disparities exist across populations and decide how to allocate resources to improve access and health outcomes.

Improving access to culturally appropriate care. Language or literacy barriers – particularly for recent immigrants – can make it more difficult for women of color to receive the care they need. Under the ACA, insurers must increase access to health care information (including providing language services at no cost) for people with low literacy levels or limited English proficiency.[15] Health care providers can receive additional training on providing care that is culturally competent.[16] The ACA also includes a variety of initiatives to increase the diversity of the health care workforce.[17]

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1 The Henry J. Kaiser Family Foundation. (2013). *Distribution of Nonelderly Adults with Medicaid by Gender.* Retrieved 15 August 2015, from http://kff.org/medicaid/state-indicator/distribution-by-gender-4/

2 National Women's Law Center. (2012, November). *What the Medicaid Eligibility Expansion Means for Women*. Retrieved 15 August 2015, from http://www.nwlc.org/resource/what-medicaid-eligibility-expansion-means-women

3 In 2014, Medicaid eligibility expanded to individuals and families with household family income at or below 133 percent FPL. However, a standard 5 percent income disregard used when determining eligibility effectively raises the limit to 138 percent FPL.

4 Values calculated by National Partnership based on data from: U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services. (2015). *2015 Poverty Guidelines.* Retrieved 22 October 2015, from http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf

5 Georgetown University Health Policy Institute. (2015). *2015 Federal Poverty Level Guidelines.* Retrieved 15 August 2015, from http://ccf.georgetown.edu/wp-content/uploads/2015/01/2015-Federal-Poverty-Guidelines.pdf

6 Ibid.

7 U.S. Dept. of Health and Human Services. (2014, December). *Lifetime & Annual Limits.* Retrieved 15 August 2015, from http://www.hhs.gov/healthcare/rights/limits/

8 National Asian Pacific American Women's Forum. *Affordable Health Care Under Attack – What's at Stake?* Retrieved 15 August 2015, from http://napawf.org/wp-content/uploads/2011/04/WhatisatStake.pdf

9 Center for American Progress. (2012, May). The Top 10 Benefits Women of Color Are Seeing Under Obamacare. Retrieved 15 August 2015, from http://www.americanprogress.org/issues/race/news/2012/05/02/11570/the-top-10-benefits-women-of-color-are-seeing-under-obamacare/

10 Centers for Disease Control and Prevention. (2015, August). Breast Cancer Rates by Race and Ethnicity. Retrieved 15 August 2015, from http://www.cdc.gov/cancer/breast/statistics/race.htm

11 U.S. Dept. of Health and Human Services, Health Resources and Services Administration. *Women's Preventive Services Guidelines*. Retrieved 15 August 2015, from http://www.hrsa.gov/womensguidelines/

12 The 30 for 30 Campaign. (2012, July). *Affordable Care Act Priorities and Opportunities for Addressing the Critical Health Care Needs of Women Living with and at Risk for HIV*. Retrieved 15 August 2015, from http://www.taepusa.org/Portals/0/30-for-30-ACA-Exec-Summary.pdf

13 See note 11.

14 Some employers – nonprofit organizations that hold themselves out as religious and certain closely-held for-profit corporations – are eligible for an accommodation that allows them not to pay for coverage of contraception, but ensures that their employees receive contraceptive coverage directly from the insurer, or for self-insured plans, the third party administrator.

15 Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. (2012, August). *Overview of Health Coverage for Individuals with Limited English Proficiency*. Retrieved 15 August 2015, from http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8343.pdf; also see note 9.

16 See note 9.

17 Robert Wood Johnson Foundation. (2011, December). *How Will the Affordable Care Act Help Diversity the Health Care Workforce?* Retrieved 15 August 2015, from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71998