

The Affordable Care Act: Increasing Access to Health Care for Lower-Income Women & Families

ISSUE BRIEF

High health care costs – along with the common practice of charging higher insurance premiums based on sex – leave many lower-income women with no or inadequate health insurance, little access to health services, and risk for economic ruin if they or a family member fall ill. The Affordable Care Act (ACA) makes a number of changes to our health care system to lessen this burden on lower-income women.

Background

Higher Rates of Poverty

Overall, women are more likely to be poor than men, especially minority women and female heads of household with no husband present. Poverty rates for unmarried female householders with children are particularly high, and have consistently been two or three times as high as overall male and female poverty rates since 1966¹ – and numbers of unmarried female householders are on the rise.² Poverty rates are even greater for minority women. In 2009, slightly more than one-quarter of both Black females (28 percent) and Hispanic females (27 percent) had family incomes below the poverty line, compared to 11 percent of White, non-Hispanic females.³

Higher Health Care Costs and Gender Rating

The high cost of health care already places a distinctive burden on women, who are more likely to need and use health services but often struggle to pay for premiums due to lower wages and time out of the workforce to meet family caregiving responsibilities. The problem has been exacerbated because many insurers charge women higher rates simply because of their gender. That puts premiums out of reach for many lower-income women. And the more affordable, low premium plans that some women turned to had dramatically higher out-of-pocket costs and left women at risk for economic ruin if they or a family member fell ill. In 2007, 62% of personal bankruptcies were linked to medical expenses – even though 80% of those had health insurance coverage. More than half of those bankruptcies were filed by female-headed households.⁴

Delaying or Foregoing Care Due to Cost

More than half of women report having delayed health care because of cost. Women – in particular lower-income women⁵ – disproportionately forego filling prescriptions, seeing specialists, seeing doctors, or getting recommended medical tests, and are also more likely to skip tests and screenings due to associated costs.⁶

The ACA makes a number of changes to our health care system to increase affordability and access to health care for lower-income women, including the following:

Medicaid Expansion and Improvements

Medicaid covers essential care over the spectrum of women's lives, from family planning and maternal health services to nursing home care. Currently, women make up three-quarters of the adult Medicaid population.⁷ It is the only source of health care for millions of vulnerable older women with multiple health problems, covering the home and community-based services and long-term care that

they urgently need. The ACA makes important improvements and expansions in Medicaid coverage.

Medicaid Expansion for Lower-Income Americans

Today, a woman without dependent children could be penniless and still not be eligible for Medicaid in most states.⁸ Starting in 2014, Medicaid eligibility will be expanded to all Americans with a family income at or below 133 percent of the Federal Poverty Level (FPL). That means a childless women earning up to \$14,520 a year will qualify for Medicaid, as will a family of three earning up to a \$24,706.

Expansion of Family Planning Coverage

For women of reproductive age the news is even better – the law allows states to act quickly and more easily to expand access to family planning services for lower-income women who would otherwise not be covered for these important preventive services. Effective immediately, states have the option to expand Medicaid eligibility for family planning services up to the same eligibility they use for pregnant women without having to go through the cumbersome federal waiver process. Most states typically provide coverage to pregnant women at or near 200% of poverty – levels far above eligibility for all other populations. Studies have found that Medicaid family planning expansions not only expanded access to care, but also improved the geographic availability of reproductive health services, expanded the diversity of providers, and reduced unintended pregnancy-- in addition to generating savings to both the federal and state governments.⁹

Better Care for Medicaid Beneficiaries with Multiple Chronic Conditions

The ACA gives states the option of providing care to Medicaid beneficiaries with chronic conditions through a “health home” model. The new Medicaid state option will permit Medicaid enrollees with at least two chronic conditions to designate a provider as a health home. States that implement this option will receive enhanced financial resources to support “health homes” in their Medicaid programs. In a health home, a team of health professionals – that can include doctors, nurses, social workers, health educators, pharmacists, and others – work together to provide coordinated, comprehensive, “whole person” care to patients. The health home improves access to primary care and puts an increased focus on preventive care to help patients stay healthy and manage their conditions.

The ACA also will provide increased federal assistance to states that offer home and community attendant services for Medicaid enrollees with disabilities to help them stay in their homes and out of institutions like nursing homes.

New Protections and Benefits in the Private Insurance Market

Even in 2014, not all lower-income women will be eligible for Medicaid. Women who earn more than 133 percent of the Federal Poverty Level in a given year must buy their health insurance on the private market. The ACA includes critical protections to the private insurance market that will make health insurance more affordable and accessible for them – and for millions of other women.

No-Cost Coverage of Preventive Services

Insurers are required to cover a core set of preventive services without cost-sharing requirements such as co-pays, co-insurance, or deductibles. For women, services such as annual mammograms and cervical cancer screenings will now be covered without any out-of-pocket costs for the patient. HHS will soon recommend additional preventive services for women that plans will be required to cover without cost-sharing. It is expected that family planning services will be included in the new

requirements. Private plans also must cover screenings and vaccinations critical to children's health without out-of-pocket costs.

Insurers cannot charge higher costs for emergency services that are obtained outside of their provider network. This will help protect women from financial hardship if they get sick or injured when they are away from home or not near a network hospital.

New Limits on Out-of-Pocket Costs

In addition, insurers can no longer impose lifetime dollar-value caps on coverage and must comply with limits on annual cost-sharing. By 2014, annual dollar-value caps on coverage will also be banned. This means when women have chronic conditions like diabetes or suffer from catastrophic illnesses or injuries, their insurance plans can't cut off their coverage simply because of expensive claims accumulated over the course of their lifetime or the plan year.

Limits on Premiums

Insurers receiving federal funds may not discriminate on the grounds of race, national origin, gender, age, or disability. These insurers may not charge higher premiums for women or unreasonable out-of-pocket costs for services disproportionately used by women or the other protected classes. Starting in 2014, no insurers in the individual market will be able to charge women more because of their gender or because of their health status or history. Insurers will only be able to vary the amount they charge for a premium based on family size, age (but only within a restricted range), and smoking status.

Insurers must spend at least 80-85% of premium dollars on providing beneficiaries with health care and improving the quality of their care, and NOT on administrative costs and profits. If an insurer doesn't meet this requirement, it will have to provide its beneficiaries with a rebate of the portion of premium dollars that exceeded this limit.

Financial Assistance

Starting in 2014, women may be eligible for premium and cost-sharing assistance if they purchase insurance through a health insurance exchange in the individual market. Women and families earning up to 400% of the Federal Poverty Level -- a yearly income of \$74,120 for a family of three -- will be eligible for a premium tax credit to help them afford comprehensive coverage, as well as even tighter limits on annual cost-sharing. Subsidies to help cover out-of-pocket costs will also be available to help women and families earning up to 250% of the Federal Poverty Level.

Maternity Coverage

In addition, starting in 2014, women purchasing insurance in the individual market will be guaranteed access to maternity coverage. Currently, these women often have to go without maternity benefits (and face average expenses of \$10,652 for maternity care,¹⁰ which includes nine months of prenatal care and three months of postpartum care for a delivery without complications) or purchase costly maternity coverage "riders" (often with long wait periods before the policy kicks in)¹¹ as most plans in the individual market do not cover maternity care.¹²

Unfinished Business

Abortion Coverage in the Health Care Exchange

Enactment of health care reform vastly expanded access to health care for millions of women -- except with regard to abortion care. The health care reform law prohibits federal funds from being used to pay for abortion coverage except in cases of rape, incest or life endangerment. Although today, private insurance plans generally provide abortion coverage, the health care reform law

requires insurers offering private plans that include abortion coverage in the health care exchanges to follow certain accounting procedures to collect and segregate funds that might be used to pay for abortion care. These arbitrary and unprecedented requirements infringe on the private health insurance choices of women and families and threaten the availability of private insurance plans that meet women's needs.

New Protections for Lower-Income Medicare Beneficiaries

Older women are more likely to be poor than older men, having earned less during their working years and in many cases having scaled back their careers to meet family caregiving responsibilities.¹³ Almost 11 percent of women age 65 and older are poor, compared to 7 percent of men age 65 and older.¹⁴ The ACA includes a number of changes to help older women.

Free Annual Wellness Check-Ups and Preventive Services

Since January 1st 2011, 50 million Medicare beneficiaries are eligible for free annual wellness check-ups, and as of March 2011 more than 150,000 beneficiaries have already taken advantage of this free benefit. It will include time for their health care providers to conduct comprehensive health risk assessments and create personalized prevention plans. And whether the patient is a Medicare beneficiary or continues to purchase private health insurance, services such as annual mammograms and cervical cancer screenings will now be conducted without any out-of-pocket costs for patients.

Closing the “Donut Hole”

Older women will save thousands of dollars as reform closes the Medicare prescription drug coverage gap. Last year, beneficiaries who fell in the “donut hole” received a \$250 rebate. This year, they will benefit from 50 percent off brand name drugs in the “donut hole.” By 2020, the donut hole will be closed.

Better Care for Dually Eligible Beneficiaries

People eligible for both Medicare and Medicaid (known as dual eligibles) are some of the most vulnerable, high need, high cost beneficiaries – and the lack of coordination between Medicare and Medicaid further complicates their care. The health reform law establishes a new office within the Centers for Medicare and Medicaid Services – the Federal Coordinated Health Care Office – to improve coordination between Medicare and Medicaid for dually eligible beneficiaries. This new office could help to dramatically improve the way these two important programs work together to meet patients' needs.

The ACA also establishes a demonstration project that will test programs that fully integrate care for dual eligibles. States can now apply for funds to support the design of innovative service delivery and payment models for dual eligibles. Funds are for the development of demonstration proposals that describe how a state would structure, implement, and evaluate a model to improve the quality, coordination, and cost effectiveness of care for dually eligible individuals. CMS will select demonstration projects to implement beginning in 2012, and the Center for Medicare and Medicaid Innovation will award up to 15 state program design contracts up to \$1 million each.

The bottom line: The Affordable Care Act will improve the lives of millions of lower-income women throughout the country by improving affordability and access to health care – through lower health care costs, expanded federal health care programs, financial assistance and new innovations seeking to improve care and lower costs.

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- ⁴ Himmelstein, D.U., et al. (June, 2009). Medical Bankruptcy in the United States, 2007: Results of a National Study. *The American Journal of Medicine*, 122(8), 741-746.
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The National Partnership for Women & Families is a non-profit, non-partisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at www.nationalpartnership.org.