ASPE
ISSUE BRIEF

THE AFFORDABLE CARE ACT: PROMOTING BETTER HEALTH FOR WOMEN

June 14, 2016

By Adelle Simmons, Jessamy Taylor, Kenneth Finegold, Robin Yabroff, Emily Gee, and Andre Chappel

ASPE thanks the Agency for Healthcare Research and Quality, particularly Claudia Steiner, for their contributions to this report.

The Affordable Care Act promotes better health for women through the law's core tenets of access, affordability, and quality. For example, the law's provisions have expanded coverage through the Health Insurance Marketplaces and Medicaid expansions; made coverage more affordable through premium tax credits and by eliminating gender differences in premiums in the individual and small-group insurance markets; and improved quality of coverage by eliminating lifetime and annual dollar limits on Essential Health Benefits and requiring coverage of recommended preventive services and maternity care. Continued implementation of the Affordable Care Act will play a significant role in promoting the health and well-being of women across the lifespan. This report is organized into three sections that describe how health care access, affordability, and quality of care have improved for women since enactment of the Affordable Care Act.

Key Highlights:

- **Health insurance coverage increased:** Between 2010 and 2015, the uninsured rate among women ages 18 to 64 decreased from 19.3 percent to 10.8 percent, a relative reduction of 44 percent.

- **Coverage gains through the Marketplaces:** About 12.7 million Americans selected affordable, quality health plans through the Health Insurance Marketplaces for 2016 coverage. Of that total number, 6.8 million (53.6 percent) are women and girls.

- **Preventive services at no out-of-pocket cost:** Because of the Affordable Care Act, an estimated 55.6 million women with private insurance are guaranteed coverage of recommended preventive services with no out-of-pocket costs.

- **Improved access to care:** The percentage of women with a usual source of care has increased since 2010, particularly among young women (a 5.2 percentage point increase between 2010 and 2014), Black women (a 5.1 percentage point increase), Hispanic women (a 6.5 percentage point increase), and women with incomes at or below 400 percent of the federal poverty level (a 3.8 percentage point increase).

- **Reductions in delayed care:** From 2010 to 2014, the proportion of young women who reported delaying or forgoing care because of cost concerns dropped by 3.4 percentage points; the proportion dropped by 3.5 percentage points among Black women, 4.1 percentage points among Hispanic women, and 3.0 percentage points among women with incomes at or below 400 percent of the federal poverty level.

- **Protection from hospitalization costs:** Women in Medicaid expansion states were much less likely to be uninsured during a hospitalization than women in non-expansion states. The total number of inpatient hospital discharges accounted for by uninsured women ages 19-64 declined by 50.5 percent between 2010 and 2014 in Medicaid expansion states versus 4.0 percent in non-expansion states.

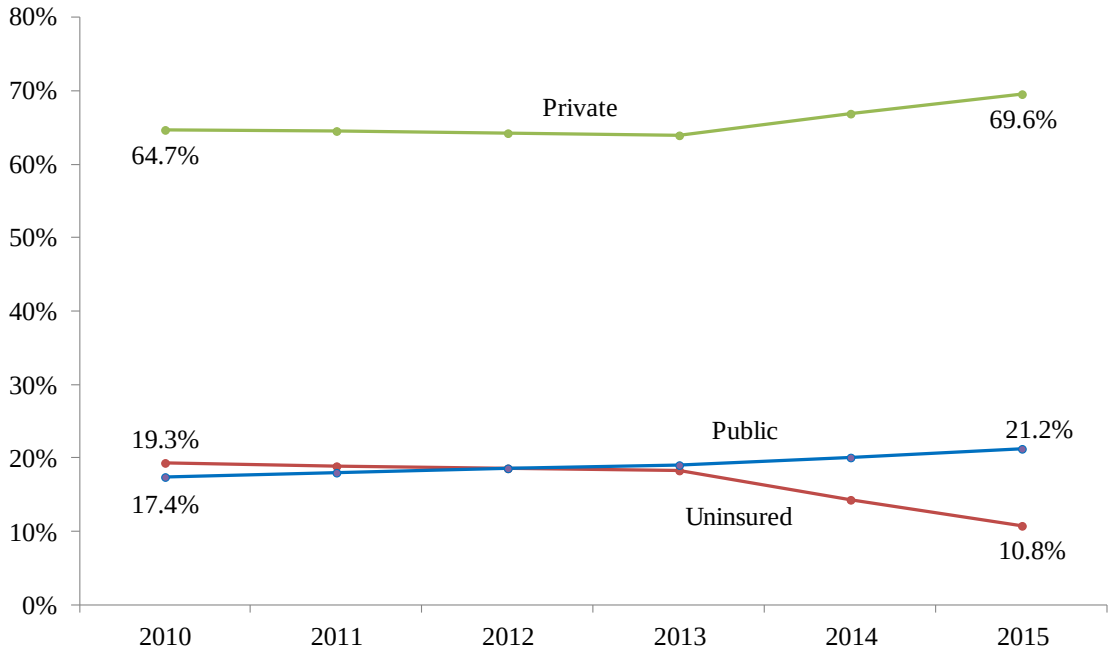
- **Improved outcomes for pregnant women and newborns:** Babies born full-term have better outcomes than babies who are electively delivered in the early term period. Between 2010 and 2013, there was a 70.4 percent reduction in early elective deliveries among hospitals participating in the HHS Strong Start for Mothers and Newborns Initiative. As of May 2014, more than 25,000 early elective deliveries were prevented.

- **Better drug coverage under Medicare**: More than 6 million women with Medicare prescription drug coverage have saved $11 billion on prescription drugs since 2010.

I. Improving Access to Health Insurance Coverage

In October 2013, at the start of the first (2014) open enrollment period for the Marketplaces, more than 15.9 million women ages 18 to 64 were uninsured.[1] In addition to its early coverage improvements, the Affordable Care Act made health coverage easier to obtain through the creation of the Health Insurance Marketplaces and the expansion of Medicaid starting in 2014. The percentage of nonelderly women (ages 18-64) who were uninsured fell slightly from 2010 to 2013, as public coverage, including enrollment in Medicaid, increased; see Figure 1 below. Uninsured rates among women dropped more sharply in 2014 and 2015, with increased private coverage, including Marketplace coverage, estimated to account for most of the gains. Between 2010 and 2015, the uninsured rate among nonelderly women decreased from 19.3 percent to 10.8 percent for a relative reduction of 44 percent, and the share with private coverage increased from 64.7 percent to 69.6 percent.

Figure 1: Insurance Coverage among Women ages 18-64 (2010 to 2015)



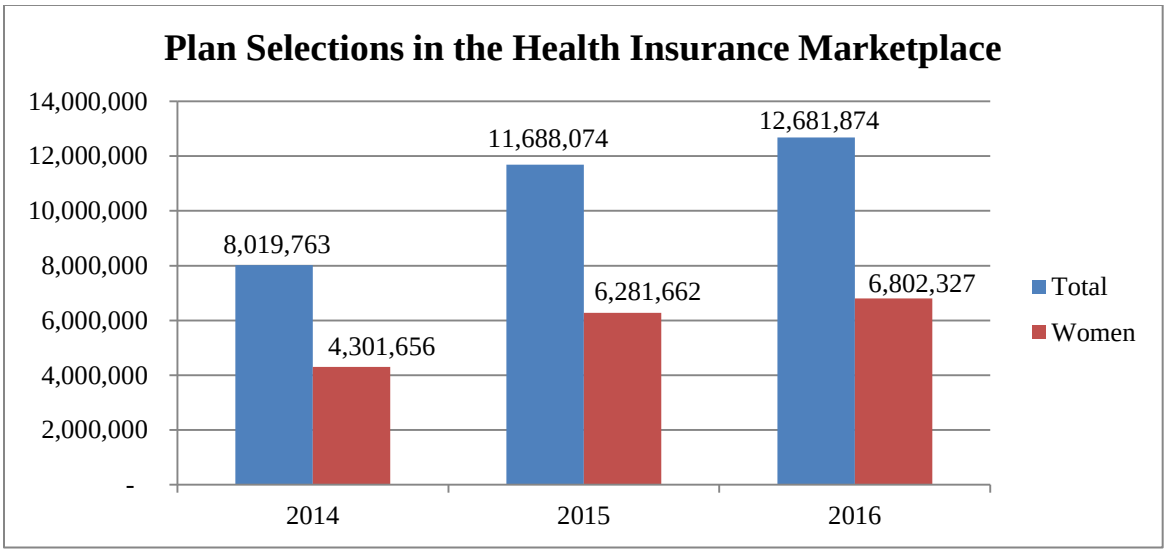
Notes: Ages 18-64. Sums may total more than 100% due to individuals reporting both public and private coverage.
Source: ASPE analysis of NHIS Early Release Program Data. U.S. Department of Health and Human Services, "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January 2010-December 2015," Table 4. http://www.cdc.gov/nchs/data/nhis/earlyrelease/quarterly_estimates_2010_2015_q1234.pdf

[1] Estimates of the "eligible uninsured" are ASPE tabulations of nonelderly (age 0-64) uninsured U.S. citizens and others lawfully present from the 2012 American Community Survey Public Use Microdata Sample, adjusted to exclude estimated undocumented persons based on imputations of immigrant legal status in ASPE's TRIM3 microsimulation model.

Health Insurance Marketplaces

About 12.7 million Americans selected health plans for 2016 coverage through the Health Insurance Marketplaces.[2] Of the total number who selected a Marketplace Plan during the 2016 Open Enrollment period, 6.8 million (53.6 percent) are women and girls.[3] Figure 2 demonstrates the size of Marketplace enrollment since 2014 and the number of women enrollees of all ages.

Figure 2: Marketplace Enrollment among Women and Girls (2014 to 2016)



Source: ASPE analysis of CMS Marketplace enrollment data.

Medicaid and CHIP

In 2014, Medicaid and the Children's Health Insurance Program (CHIP) served 13 percent of women ages 19 to 64 in the U.S.[4] The Affordable Care Act improved access to Medicaid coverage in several notable ways. Medicaid's expansion of eligibility to low-income adults with incomes below 138 percent of the federal poverty level has expanded access to Medicaid coverage to millions of low-income women in the 32 states that have adopted the expansion to date, and has the potential to benefit millions more in the states that have not yet implemented the expansion. This group includes low-income parents and pregnant women, who otherwise lose Medicaid coverage two months following delivery of their newborn. Coverage through Medicaid increases access to quality health care and improves the financial security for low-income individuals.

[2] This amount does not include 400,000 people who signed up on the New York and Minnesota Marketplaces for coverage through the Basic Health Program during this Open Enrollment. HHS Fact Sheet: About 12.7 million people nationwide are signed up for coverage during Open Enrollment. February 4, 2016. http://www.hhs.gov/about/news/2016/02/04/fact-sheet-about-127-million-people-nationwide-are-signed-coverage-during-open-enrollment.html#

[3] Percentages are based on those who reported age/gender. The number of women presented in the graph is women and girls of all ages. Additional information about 2016 Open Enrollment Period is available at https://aspe.hhs.gov/pdf-report/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report.

[4] ASPE analysis of 2014 NHIS public use data.

The Affordable Care Act also amended the Medicaid statute to create a new optional eligibility group such that states now have the option to provide family planning-related services and supplies to women who previously only received coverage through section 1115 family planning demonstration projects. To date, fourteen states have adopted the new family planning eligibility group.

II. Improving Affordability

Delayed or Forgone Care

Since the implementation of the Affordable Care Act, fewer women report having delayed or forgone care because of cost concerns. The proportion of young women (age 18-26) who reported delaying or forgoing care dropped by 3.4 percentage points between 2010 and 2014; the proportion dropped by 3.5 percentage points among Black women, 4.1 percentage points among Hispanic women, and 3.0 percentage points among women with incomes at or below 400 percent of the federal poverty level (Table 1).[5]

Table 1: Percentage of Women Who Had to Delay or Forgo Care because of Cost (Weighted Percentages)

	2010	2011	2012	2013	2014	Change (percentage points)
Age						
18-26	15.5%	15.6%	13.3%	12.0%	12.1%	-3.4
27-39	16.6%	15.8%	15.7%	14.5%	13.9%	-2.7
40-49	16.6%	18.6%	16.7%	14.9%	14.1%	-2.5
50-64	17.2%	16.2%	16.4%	15.6%	14.1%	-3.1
65+	5.4%	5.2%	4.6%	4.6%	5.0%	-0.4
Race/ethnicity						
White, non-Hispanic	13.7%	13.5%	12.9%	11.8%	11.6%	-2.1
Black, non-Hispanic	18.6%	18.3%	15.9%	16.8%	15.1%	-3.5
Hispanic	17.0%	17.2%	16.2%	14.0%	12.9%	-4.1
Asian/PI	6.8%	7.0%	7.0%	6.0%	5.5%	-1.3
Other	12.3%	14.7%	12.0%	11.5%	9.1%	-3.2
Income as % of federal poverty level						
≤400%	19.7%	19.9%	18.6%	17.5%	16.7%	-3.0
>400%	7.4%	5.9%	5.8%	4.9%	4.8%	-2.6
Missing	9.0%	10.4%	9.6%	9.5%	5.7%	-3.3

Source: ASPE analysis of NHIS 2010-2014.

[5] All four trends are statistically significant (p-value<0.05).

Medicaid Expansion and Hospital Care

A particular point of financial vulnerability for women is the cost of hospital care, which is often expensive and may not be planned. In states that expanded Medicaid under the Affordable Care Act, women were less likely to be left uninsured during a hospitalization than in states that did not expand Medicaid.[6] The proportion of inpatient hospital discharges attributable to uninsured women in states that expanded Medicaid dropped by 3.3 percentage points from 7.1 percent in 2010 to 3.8 percent in 2014; in contrast, in non-expansion states, the proportion of inpatient discharges attributable to uninsured women decreased by only 1.7 percentage points from 8.0 percent to 6.3 percent.[7] Put another way, the number of uninsured hospitalizations in Medicaid expansion states decreased by 50.5 percent (from 381,776 in 2010 to 188,798 in 2014), while the number of uninsured hospitalizations in non-expansion states decreased by only 4.0 percent (from 415,438 in 2010 to 398,745 in 2014).[8] This coverage trend demonstrates the financial protections created by the Affordable Care Act, and Medicaid expansion in particular, and helps explain why hospitals in Medicaid expansion states also have more significant reductions in uncompensated care since passage of the Affordable Care Act than hospitals in non-expansion states.[9]

Medicare Prescription Drugs

Prior to the Affordable Care Act, Medicare Part D beneficiaries experienced a coverage gap in their prescription drug coverage, termed the "donut hole". The Affordable Care Act closes the donut hole over several years until it is completely closed in 2020. Since this Affordable Care Act provision went into effect in 2010 through 2015, beneficiaries with Medicare prescription drug coverage have saved more than $20 billion on prescription drugs -- including savings of $11 billion for the more than 6 million women with Medicare Part D.[10] Concurrently, women with Medicare Part D note an improvement in affordability, with a 3.8 percentage point decline in the proportion of women saying they could not afford prescription medication in the past 12 months (Table 2).[11]

---

[6] Hu, L, Kaestner, R, Mazumder, B, Miller, S, Wong, A. "The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being," National Bureau of Economic Research, Working Paper 22170, April 2016. http://www.nber.org/papers/w22170.

[7] AHRQ analysis of 2010 and 2014 Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID) data. For this analysis, Expansion States include AR, AZ, CA, CO, CT, HI, IA, IL, KY, MD, MI, MN, NJ, NM, NV, NY, OH, OR, RI, VT, WA, WV (n=22); Nonexpansion States include FL, GA, IN, KS, LA, MO, MT, NC, NE, OK, PA, SC, SD, TN, TX, VA, WI, WY (n=18). Four States (IN, LA, MT, PA) that expanded their Medicaid programs in 2015 or 2016, are considered as Nonexpansion States for this analysis.

[8] Agency for Healthcare Research and Quality (AHRQ) analysis of Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 2010 and 2014.

[9] HHS, Office of the Assistant Secretary for Planning and Evaluation, 2015. ASPE Issue Brief: Insurance Expansion, Hospital Uncompensated Care, and the Affordable Care Act. https://aspe.hhs.gov/pdf-report/insurance-expansion-hospital-uncompensated-care-and-affordable-care-act

[10] ASPE estimated the number of women who had Medicare Part D savings during 2010-2015 based on CMS's estimated total number of beneficiaries with Part D savings (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-02-08.html) and the ratio of female to total non-Low Income Subsidy beneficiaries generated from Medicare Prescription Drug Event (PDE) data.

[11] This trend is statistically significant (p-value<0.001).

Table 2: Trends in Prescription Drug Affordability for Women Medicare Part D Beneficiaries, Ages 65+, Unadjusted

	2011	2012	2013	2014	Change (percentage points)
Prescription Drug Affordability					
Skipped medication doses	6.8%	5.1%	5.1%	4.8%	-2.0
Took less Medicine	7.6%	5.1%	5.3%	4.8%	-2.8
Delayed filling a prescription to save money	8.9%	6.7%	7.1%	6.5%	-2.4
Any limitation in prescription drug affordability (Any Above)	10.8%	7.7%	8.5%	7.8%	-3.0
Asked your doctor for a lower cost medication	25.6%	24.3%	21.3%	21.2%	-4.4
Bought prescription drugs from another country	2.1%	1.1%	1.6%	1.4%	-0.7
Could not afford prescription medication, past 12 months	10.2%	6.8%	7.2%	6.4%	-3.8

Source: ASPE Analysis of NHIS 2011-2014.

III. Improving Quality of Coverage and Health Care

Preventive Health Services

The Affordable Care Act requires most private health insurance plans to cover preventive benefits recommended by the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices without cost-sharing. For example, since September 23, 2010, non-grandfathered plans subject to this requirement must cover recommended services including mammograms, screenings for cervical cancer, tobacco cessation services, and flu and pneumonia shots without cost-sharing.[12] The Affordable Care Act also enhanced Medicare coverage of recommended preventive services, including screening mammograms, by waiving cost-sharing (coinsurance or deductible) that would otherwise apply. In addition, Medicare beneficiaries can now get a free Annual Wellness Visit. The Affordable Care Act aligned Medicaid coverage for the newly eligible with that offered by private insurance by covering the ten essential health benefits through alternative benefit plan (ABP) coverage. This means that women covered through Medicaid expansion have access to preventive services and other coverage similar to that offered in the private insurance market, including access to all eighteen Food and Drug Administration approved contraceptives.

[12] HHS. *Preventive care benefits: Preventive health services for adults*. https://www.healthcare.gov/preventive-care-benefits/

The Affordable Care Act also included a provision that took effect beginning on August 1, 2012, requiring most insurers to cover certain additional recommended preventive health services – established under the Women's Preventive Services Guidelines[13] – without charging a copay, coinsurance, or deductible. Millions have gained expanded coverage of these services including contraceptive education, counseling, methods, and services; well-woman visits; sexually-transmitted infection counseling; Human Immunodeficiency Virus (HIV) screening and counseling; screening for gestational diabetes, breastfeeding support, supplies, and counseling; and domestic violence screening and counseling – all without cost sharing. [14] It is estimated that 55.6 million women with private insurance are guaranteed coverage of recommended preventive services with no out-of-pocket costs.[15] Not having to face the barrier of cost sharing for women's preventive services means greater access to recommended screenings and other services that can help protect women's health, and access to family planning services to help women space their pregnancies to promote optimal birth outcomes. [16]

Usual Source of Care

As shown in Table 3, there have been gains in the percentage of women with a usual source of care, particularly among young women (a 5.2 percentage point increase between 2010 and 2014), Black women (a 5.1 percentage point increase), Hispanic women (a 6.5 percentage point increase), and women with incomes at or below 400 percent of the federal poverty level (a 3.8 percentage point increase).[17]

[13] The Health Resources and Services Administration awarded a five-year cooperative agreement to the American College of Obstetricians and Gynecologists to develop a collaborative process to review and recommend updates to the guidelines. http://www.hrsa.gov/womensguidelines/updatingwomensguidelines.html

[14] HRSA. *Women's Preventive Services Guidelines*. http://www.hrsa.gov/womensguidelines/

[15] HHS, Office of the Assistant Secretary for Planning and Evaluation, 2015. *ASPE Data Point: The Affordable Care Act is Improving Access to Preventive Services for Millions of Americans*. https://aspe.hhs.gov/pdf-document/affordable-care-act-improving-access-preventive-services-millions-americans

[16] Institute of Medicine, 2011. *Clinical Preventive Services for Women: Closing the Gaps*. http://iom.nationalacademies.org/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx#sthash.350trMBF.dpuf

[17] All four trends are statistically significant ($p<0.01$).

Table 3: Percentage of Women with a Usual Source of Care (weighted percentages)

	2010	2011	2012	2013	2014	Change (percentage points)
Age						
18-26	75.3%	77.7%	75.1%	75.5%	80.5%	5.2
27-39	81.1%	82.2%	81.3%	81.0%	83.8%	2.7
40-49	87.2%	88.1%	85.4%	87.7%	89.5%	2.3
50-64	89.4%	91.5%	89.7%	91.4%	91.9%	2.5
65+	95.8%	96.0%	95.9%	96.3%	96.7%	0.9
Race/ethnicity						
White, non-Hispanic	89.1%	90.3%	88.7%	89.3%	91.1%	2.0
Black, non-Hispanic	83.0%	85.0%	83.9%	86.7%	88.1%	5.1
Hispanic	74.3%	76.3%	76.5%	77.6%	80.8%	6.5
Asian/Pacific Islander	86.8%	86.4%	84.3%	85.7%	87.4%	0.6
Other	82.0%	84.6%	82.3%	84.3%	87.5%	5.5
Income as % of federal poverty level						
≤400%	82.2%	83.1%	82.7%	82.8%	86.0%	3.8
>400%	92.5%	94.9%	92.5%	93.9%	93.8%	1.3
Missing	88.0%	89.1%	84.8%	88.2%	91.2%	3.2

Source: ASPE analysis of NHIS 2010-2014.

Maternity Care

The Affordable Care Act also funded the Strong Start for Mothers and Newborns Initiative, a collaborative effort by the Centers for Medicare & Medicaid Services (CMS), the Health Resources and Services Administration, and the Administration on Children and Families, to reduce preterm births and improve health outcomes for newborns and pregnant women.[18] In the first stage of this initiative, sites participating in the Partnership for Patients identified and disseminated best practices to reduce the number of early elective deliveries among pregnant women. Between 2010 and 2013, there was a 70.4 percent reduction in early elective deliveries among participating hospitals,[19] and, as of May 2014, more than 25,000 early elective deliveries were prevented.[20,21] Close to 200 sites are currently participating in an initiative to test and evaluate enhanced prenatal care interventions for women enrolled in Medicaid or CHIP who are at risk for having a preterm birth.

[18] HHS, Centers for Medicare & Medicaid Services. *Strong Start for Mothers and Newborns Initiative: General Information.* Accessed at http://innovation.cms.gov/initiatives/strong-start/

[19] CMS Fact Sheet (July 30, 2015). https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-30-3.html

[20] March of Dimes. *2015 Annual Report.* http://www.marchofdimes.org/materials/2015-annual-report.pdf

[21] HHS Office on Women's Health. *2015 Report to Congress: HHS Activities to Improve Women's Health*.

As mentioned above, in addition to funding the Strong Start for Mothers and Newborns Initiative, the Affordable Care Act amended the Medicaid program by requiring states to cover counseling and pharmacotherapy for cessation of tobacco use by pregnant women with no cost sharing. This new mandatory Medicaid benefit aligns with the services recommended by the U.S. Preventive Services Task Force.

IV. Conclusion

Numerous provisions of the Affordable Care Act address the unique health care needs of women, and the resulting impacts are clear through improvements in access, affordability, and quality of coverage and care. As implementation of the Affordable Care Act continues, provisions designed to strengthen preventive care, ensure the availability of affordable insurance coverage options, and improve health care delivery for all Americans will continue to promote better health outcomes for women.