What does the Affordable Care Act mean for the health of women, children, and families?

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Drivers of Health Care Reform

Cost

Access

Quality

Variable, not so great....
Exhibit 1: National Health Expenditures per Capita, 1990-2018

- $2.5 trillion in 2009
- $8,160 in 2009
Increase in number of uninsured

Drop in Employer-Sponsored Coverage

Who cares?

American families!
The White House Blog
Health Insurance Reform as a Women’s Issue:
The First Lady’s Take

Women’s Issues and Women’s Groups Key in Health Reform Debate

Healthcare Reform in America - You can make a difference!

AMA president says pregnant women are barred from buying individual health policies

March of Dimes Calls for Health Coverage for Women of Childbearing Age and Children

What’s Wrong with ObamaCare?

Comprehensive Health Care Reform: An Essential Prescription for Women
A Report by the Joint Economic Committee
Representative Carolyn B. Maloney, Chair
Senator Charles E. Schumer, Vice Chair
As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?

Source: Kaiser Family Foundation Health Tracking Polls
If there were any question that the ACA is intended to address family health....

“Today, I’m signing this reform bill into law on behalf of my mother, who argued with insurance companies even as she battled cancer in her final days.”

• President Obama, March 23, 2010

http://www.whitehouse.gov/blog/2010/03/23/behalf-my-mother
Key Elements of Health Reform
From a Family Perspective

• What does the new law do?
• How will this help uninsured women, children, and families?
• Will it change anything for families who currently have coverage?
• Key issues for women and children:
  – Affordability
  – Preventive Services & Primary Care
  – Reproductive Health
What does the new law do?
How will Health Reform Affect Access to and Affordability of Coverage for Women and Families?

At the time the law was passed (2010):
- Temporary high-risk pools
- Extend dependent coverage to age 26
- No lifetime limits and no rescissions; restricted annual limits
- No pre-existing condition exclusions for children
- Review increases in health plan premiums

When the law is fully implemented (2014):
- Having insurance coverage becomes mandatory
- New preventive benefits without cost sharing
- Medicaid Expansion for those below <138% Federal Poverty Level
- New avenues for purchasing private coverage: Access to Exchanges for >138% FPL and small employers
11 facts about the Affordable Care Act

1. By 2022, the CBO estimates the Affordable Care Act will have extended coverage to 33 million Americans who would otherwise be uninsured.

2. Coverage expansion and subsidies for low-income families

- Families making less than 133 percent of the poverty line — that’s about $29,000 for a family of four — will be covered through Medicaid.

- Between 133 percent and 400 percent of the poverty line — $88,000 for a family of four — families will get tax credits on a sliding scale to help pay for private insurance.
3. Affordability

For families <400% FPL, premiums are capped.

- For example, families 150% - 200% FPL won’t have to pay more than 6.3 percent of their income in premiums

4. Penalties

When the individual mandate is fully phased-in, those who can afford coverage — which is defined as insurance costing less than 8 percent of their annual income — but choose to forgo it will have to pay either $695 or 2.5 percent of the annual income, whichever is greater.
5. Tax credits for small business

• Small businesses that have fewer than 10 employees, average wages beneath $25,000, and that provide insurance for their workers will get a 50 percent tax credit on their contribution.

• Tax credit reaches up to small businesses with up to 50 employees and average wages of $50,000, though it gets smaller as the business get bigger and richer.

6. No preexisting conditions exclusions

• Insurance companies are not allowed to discriminated based on preexisting conditions.

• They are allowed to discriminate based “on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio).”
7. Tax on “Cadillac” Plans
   • Starting in 2018, the law imposes a 35 percent tax on employer-provided health plans that exceed $10,200 for individual coverage and $27,500 for family coverage.

8. Medical Loss Ratio
   • The law requires insurers to spend between 80 and 85 percent of every premium dollar on medical care (as opposed to administration, advertising, etc).
   • If insurers exceed this threshold, they have to rebate the excess to their customers.
   • This policy is already in effect, and insurers are expected to rebate $1.1 billion this year
9. The math

- Costs: The law is expected to spend a bit over $1 trillion in the next 10 years.

- Savings: The law’s spending cuts — many of which fall on Medicare — and tax increases are expected to either save or raise a bit more than that.

- Over time: As time goes on, the savings are projected to grow more quickly than the spending, and CBO expects that the law will cut the deficit by around a trillion dollars in its second decade.
Estimated Effects of PPACA and the Health Care Provisions of the Reconciliation Act on the Federal Budget

(Billions of dollars, by fiscal year)

Net Changes from Insurance Coverage Provisions
Net Changes in Other Revenues
Net Changes in Other Spending

Net Increase or Decrease in the Deficit
10. ACA and Health Care Costs

• In recent years, health-care costs have slowed dramatically.
• Much of this is likely due to the recession. Some of it may just be chance.
• But there’s also evidence that the law has accelerated changes in the way the medical system delivers care, as providers prepare for the law’s efforts to move from fee-for-service to quality-based payments.

11. Controlling Future Costs
The law’s long-term success at controlling costs will likely hinge on its efforts to change the way health care is delivered, most of which have gotten very little attention.
How will this help uninsured women, children, and families?
Uninsured Rates Among Nonelderly by State, 2010-2011

- <14% uninsured (13 states & DC)
- 14 to 18% uninsured (20 states)
- >18% uninsured (17 states)

National Average = 18.2%

SOURCE: KCMU/Urban Institute analysis of 2011 and 2012 ASEC Supplement to the CPS (two-year pooled data).
# Health Insurance Coverage of Low-Income Adults and Children, 2011

<table>
<thead>
<tr>
<th></th>
<th>Employer/Other Private</th>
<th>Medicaid/Other Public</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor (&lt;100% of Poverty)</td>
<td>14%</td>
<td>71%</td>
<td>15%</td>
</tr>
<tr>
<td>Near-Poor (100%-199%</td>
<td>35%</td>
<td>51%</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Parents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>16%</td>
<td>43%</td>
<td>41%</td>
</tr>
<tr>
<td>Near-Poor</td>
<td>44%</td>
<td>22%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Adults without</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>28%</td>
<td>30%</td>
<td>42%</td>
</tr>
<tr>
<td>Near-Poor</td>
<td>39%</td>
<td>24%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Data may not total 100% due to rounding.

SOURCE: KCMU/Urban Institute analysis of 2012 ASEC supplement to the CPS.
Trends (2000-2009) in the percentage of U.S. women of childbearing age (18-49) who were uninsured at some point in the prior year, by pregnancy status

96.2 million women ages 18-64

19.1 million uninsured

Employer 59%
Medicaid 12%
Individual 6%
Other 3%

Type of Assistance Potentially Available in 2014

- Tax Credits 139-399% 37%
- Medicaid <138% 54%
- No Subsidies ≥ 400% 9%

Other includes programs such as Medicare and military-related coverage.
The federal poverty level for a family of four in 2009 was $22,050.
Expanding Coverage to the Uninsured in 2014

- Medicaid Expansion: All individuals with incomes up to 138% Federal Poverty Level (MAGI) qualify for Medicaid.
  - undocumented and new immigrants will not qualify for Medicaid coverage

Note: Medicaid income eligibility for most elderly and individuals with disabilities is based on the income threshold of Supplemental Security Income (SSI).
Source: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2009.
Will it change anything for women and children who currently have coverage?
Changes for currently insured women and children

- Insurance reforms
- Benefits standards
- Preventive services
  - New preventive services for women
  - Family planning/contraception
  - STI screening
- Maternity care
- Primary care workforce
New Subsidies, Caps on Spending, and Insurance Market Regulations Will Provide Additional Protections in 2014

Insurance Reforms

- Modified community rating
  - Prohibit insurers from charging people more based on gender, health status, or occupation
  - Variations in premiums based on age (3 to 1) and tobacco use (1.5 to 1) would be limited
- Bans on pre-existing condition exclusions
- Guaranteed renewability (regardless of health status); prohibits annual and lifetime limits on coverage
How much more do women pay for health insurance?

Before the Affordable Care Act

After the Affordable Care Act (starting in 2014)

National Women's Law Center, "Turning to Fairness".
Based on comparable insurance plans for 25 year old women and men living in capitol cities.

Health Insurance Plans Will Be Required To Provide Coverage for Comprehensive Services in 2014

Benefit Standards (uniform benefits packages within tiers of coverage)

-- Ambulatory patient services
-- Emergency services
-- Hospitalization
-- Maternity and newborn care
-- Mental Health and substance use disorder services, including behavioral health treatments
-- Prescription drugs
-- Rehabilitative and habilitative services and devices
-- Laboratory services
-- Preventive and wellness services and chronic disease management
-- Pediatric services including dental care
Preventive Screening Services a Major New Coverage Area

US Preventive Services Task Force (USPSTF) Recommendations

- No Cost Sharing in Qualified Health Plans (2010) and Medicare (2011)

<table>
<thead>
<tr>
<th>U.S. Preventive Services Taskforce: A and B Level Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifestyle/Healthy Behaviors</strong></td>
</tr>
<tr>
<td>Alcohol Screening</td>
</tr>
<tr>
<td>Depression Screening</td>
</tr>
<tr>
<td>Healthy Diet Counseling</td>
</tr>
<tr>
<td>Tobacco interventions</td>
</tr>
<tr>
<td>Immunizations</td>
</tr>
</tbody>
</table>
New Preventive Benefits for Women

- New requirements for covering additional women’s preventive services

http://www.hrsa.gov/womensguidelines/

- A panel of experts in prevention and women’s health was convened by the Institute of Medicine to identify potential services that could be included. These recommendations were adopted by HHS in 2011.

- Effective for all new (non-grandfathered) plans, starting August 2012
<table>
<thead>
<tr>
<th>Type of Preventive Service</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-woman visits.</td>
<td>Annual.</td>
</tr>
<tr>
<td>Screening for gestational diabetes.</td>
<td>In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.</td>
</tr>
<tr>
<td>Human papillomavirus testing.</td>
<td>Screening should begin at 30 years of age and should occur no more frequently than every 3 years.</td>
</tr>
<tr>
<td>Counseling for sexually transmitted infections.</td>
<td>Annual.</td>
</tr>
<tr>
<td>Counseling and screening for human immune-deficiency virus.</td>
<td>Annual.</td>
</tr>
<tr>
<td>Contraceptive methods and counseling.**</td>
<td>As prescribed.</td>
</tr>
<tr>
<td>Breastfeeding support, supplies, and counseling.</td>
<td>In conjunction with each birth.</td>
</tr>
<tr>
<td>Screening and counseling for interpersonal and domestic violence.</td>
<td>Annual.</td>
</tr>
</tbody>
</table>
**Contraceptive methods and counseling requirement: religious exemption**

- Group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to cover contraceptive services. A religious employer is one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization under Internal Revenue Code section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii). 45 C.F.R. §147.130(a)(1)(iv)(B).

- See the Federal Register Notice: Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act (PDF - 201 KB)
Preventing Unintended Pregnancy and STIs

- **STI/HIV screening covered by task force**
  - HIV, Chlamydia, Gonorrhea, Syphilis screening are preventive services under Medicare (effective 2011) and Qualified Health Plans (2010)
  - **NO COST SHARING!**

- **Teen Pregnancy Prevention**
  - State Personal Responsibility Education Program (PREP) A new program for states to provide evidence-based sex education to reduce teen pregnancy and STIs. ($75m/year)
  - Restores State Title V Abstinence Education Grant Program ($50m/year)

### STI Rates per 100,000 people, 2009

- **Chlamydia**
  - Men: 220
  - Women: 593

- **Gonorrhea**
  - Men: 92
  - Women: 106

Maternity Care

• Maternity and newborn care defined as essential benefit in plans, details not specified yet

• Medicaid
  – Covers 42% births nationally
  – Mandatory coverage of tobacco cessation programs for pregnant women
  – Coverage for freestanding birth centers
  – Medicaid coverage for all newborns who lack acceptable coverage

• Grants to states for home visiting and postpartum depression services

• Workplace breastfeeding protections for nursing mothers
Promoting Primary Care Access and Availability

<table>
<thead>
<tr>
<th>Condition</th>
<th>18 to 44 years</th>
<th>45 to 64 years</th>
<th>65 and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability/condition limiting activity</td>
<td>9%</td>
<td>22%</td>
<td>18%</td>
</tr>
<tr>
<td>Chronic condition requiring ongoing treatment</td>
<td>23%</td>
<td>50%</td>
<td>59%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>9%</td>
<td>32%</td>
<td>61%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5%</td>
<td>20%</td>
<td>13%</td>
</tr>
<tr>
<td>Heart disease</td>
<td>2%</td>
<td>8%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Note: Chronic conditions diagnosed by physician in past 5 years.
Source: Kaiser Family Foundation, 2004 Kaiser Women’s Health Survey.

- Shortage of primary care providers addressed by increasing Medicare and Medicaid primary care rates
  - Raise Medicaid rates for primary care to Medicare rates in 2013-2014
  - Coordinate care for dually Medicaid/Medicare eligible beneficiaries
- Provide incentives for new doctors and other health professionals to practice primary care, particularly in professional shortage areas
To summarize...
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Resources and further reading

• Families USA. How health reform helps low-income children: http://www.familiesusa.org/assets/pdfs/health-reform/Low-Income-Children.pdf

• Kaiser Family Foundation. Impact of Health Reform on Women’s Coverage and Access to Care: http://www.kff.org/womenshealth/7987.cfm

• Women and Health Care Reform Blog: http://www.womenandhealthcarereform.org

• Publications:
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