



OPPORTUNITIES TO MAXIMIZE WOMEN'S HEALTH UNDER THE AFFORDABLE CARE ACT

OCTOBER 2013

A SPECIAL
REPORT FROM
GRANTMAKERS
IN HEALTH

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EXECUTIVE SUMMARY

OPPORTUNITIES TO MAXIMIZE WOMEN'S HEALTH UNDER THE AFFORDABLE CARE ACT

As the key consumers, providers, and coordinators of health care, women will be uniquely affected by national health reform. The Patient Protection and Affordable Care Act (ACA) is a significant opportunity for the United States to prioritize women's health across the lifespan. The ACA addresses women's health challenges by: 1) dramatically increasing insurance coverage, 2) making health insurance more affordable, 3) guaranteeing women comprehensive health benefits, and 4) protecting women from discriminatory insurance practices. Despite these significant strides, certain women's health challenges will persist unless specifically addressed under reform. Philanthropy is uniquely situated to address the challenges specific to women's health. Armed with recommendations gleaned from seven years of Massachusetts health reform, the model for national reform, philanthropy can play a crucial role in funding initiatives to address these remaining challenges and foster real change in women's health within the emerging health care system.

KEY FINDINGS AND RECOMMENDATIONS

Challenge	Impact of the ACA	Opportunities for Philanthropy
Preventive Care Preventive care and early detection of diseases can lead to effective treatment and improved health outcomes while cost-sharing (copayment, coinsurance, or deductible) can be a barrier to women's access to care.	Private insurers are now required to cover a range of preventive care services for women without cost-sharing, including well-woman visits; screenings for gestational diabetes; HPV DNA testing; counseling for sexually transmitted infections; counseling and screening for HIV; breastfeeding support, supplies, and counseling; screening and counseling for interpersonal and domestic violence; and Food and Drug Administration-approved contraceptive methods and contraceptive counseling.	The success of "no-cost" preventive women's services depends on strong oversight and comprehensive consumer education. <ul style="list-style-type: none"> • Support advocacy initiatives to enhance access to and utilization of the women's health preventive services. • Provide funding to monitor and evaluate access to and utilization of "no-cost" preventive services for women. • Support outreach and education to educate women and providers about "no-cost" preventive services.ⁱ
Insurance Coverage Twenty percent of women ages 18 to 64 are uninsured in the United States. Uninsurance affects a woman's ability to access and afford care.	The ACA takes a number of steps to increase insurance coverage: <ul style="list-style-type: none"> • Women under the age of 26 can remain on a parent's insurance plan. • Previously uninsured low-income women may gain coverage under Medicaid expansion if their state chooses to participate. • Women without access to employer-sponsored insurance will be able to purchase health insurance plans in the newly created state health insurance exchanges. 	<ul style="list-style-type: none"> • Provide funding to monitor the impact of a state's decision to accept or deny Medicaid expansion. • Support advocacy and public service campaigns at the grassroots level to encourage states to accept expansion. • Support safety net and pilot programs that provide alternative models of coverage for low-income women in states that do not expand Medicaid. • Invest in culturally competent outreach and enrollment efforts. • Support advocacy to ensure that young women can access confidential services, including reproductive and sexual health services under their parents' insurance plans.

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ⁱ "No-cost" preventive services: although consumers do no pay cost-sharing during a preventive care visit, they still pay for these services through premiums.

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Challenge	Impact of the ACA	Opportunities for Philanthropy
Churn & Gaps in Coverage <p>In 2014, 28 million low-income Americans are expected to transition between insurance products. This is known as "churn." It disproportionately affects women because of income and other gender-related circumstances.</p>	<p>The ACA attempts to reduce churn through the following provisions:</p> <ul style="list-style-type: none"> The Basic Health Plan would allow states to create an intermediate insurance program between Medicaid and the exchange. The "no wrong door" provision is a streamlined approach to enroll in insurance through Medicaid or state health insurance exchanges. 	<ul style="list-style-type: none"> Support advocacy programs designed to help reduce churn and gaps in coverage. Fund studies and programs to monitor and address churn and gaps in coverage for women. Support pilot studies to examine the efficacy of models designed to reduce churn.
Affordability <p>Women are disproportionately affected by health care costs for a number of gender-based reasons, including lower incomes and longer life expectancies.</p>	<p>The ACA addresses affordability by establishing health insurance exchanges where women can purchase affordable insurance and determine eligibility for tax credits and Medicaid. It also calls for the establishment of a "navigator program" to help consumers determine which subsidies they may qualify for to help with buying coverage.</p>	<ul style="list-style-type: none"> Support research to gauge the adequacy of premium subsidies for women and the law's affordability standard. Fund development of consumer affordability tools designed for women. Support advocacy programs to work with women to ensure that they are able to access affordable, comprehensive care under the ACA.
Primary Care <p>Primary health careⁱⁱ is crucial to a woman's health, yet it faces provider shortages (Mann et al. 2010). With 17 million women expected to gain insurance coverage, these shortages are likely to be exacerbated.</p>	<p>Although the ACA includes provisions designed to address recruitment, retention, and training of primary care providers (PCPs), efforts beyond the ACA provisions will be necessary to maximize PCP access and utilization for women.</p>	<ul style="list-style-type: none"> Fund research on flexible work arrangements for primary care clinicians. Support primary care workforce studies and research on issues driving provider shortages. Support the development of public-private partnerships to address workforce shortages.
Long-Term Care <p>Women are more likely to be the recipients of long-term care (LTC) over the lifespan, to work in caregiving professions, and to perform unpaid informal caregiving duties for family members and friends.</p>	<p>The ACA strengthens the formal LTC workforce through loan repayment programs and provides funding for new models of care to better address the needs of the LTC population. Because the ACA's major LTC initiative (CLASS Act) failed, philanthropy has significant opportunities to improve the LTC landscape.</p>	<ul style="list-style-type: none"> Invest in comprehensive data sets that track LTC issues and needs. Support public-private partnership strategic planning initiatives with states. Fund advocacy to improve LTC options for women. Support innovations in LTC financing. Support programs for informal caregivers.
Women's Health Research <p>Data collection and reporting standards will be essential to understand the impact that important ACA provisions have on women's health.</p>	<p>The ACA requires the collection of certain self-reported data on sex, race, ethnicity, primary language, and disability status. The law, however, does not require the routine analysis and reporting needed to ensure that health disparities are addressed under reform.</p>	<ul style="list-style-type: none"> Fund research studies that examine the impact of health reform on women and subgroups of women. Require grantees to report stratified data as a condition of funding.

ⁱⁱ Family medicine, internal medicine, obstetrics and gynecology, geriatrics, and psychiatry

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INTRODUCTION

As key consumers, providers, and coordinators of health care, women are uniquely affected by health reform. Women use more medical services than men and have higher medical expenditures over their lifetimes due in part to reproductive health care needs, higher rates of chronic diseases, and longer life expectancies (Lambrew 2001). Women also face greater challenges affording care, as they tend to have lower annual incomes and lifetime earnings. They are more likely than men to be in transitory employment arrangements, such as part-time or low-wage jobs, making them more vulnerable to changes and gaps in insurance coverage. Women are also more likely than men to be covered as a dependent on a partner's insurance, increasing the risk of losing coverage when life transitions such as the death or retirement of, or divorce from, a spouse occur. Given their roles as the primary health care decisionmakers and caregivers for their children, parents, and spouses, any challenges women face in accessing health care services will likely have an impact on entire families and communities (Salganicoff et al. 2005).

The Patient Protection and Affordable Care Act (ACA) presents a significant opportunity for the United States to prioritize women's overall health across the lifespan. The ACA uses a multipronged approach to increase insurance coverage, make insurance more affordable, ensure that benefits are comprehensive, and protect consumers from discriminatory insurance practices. In July 2012 the U.S. Supreme Court evaluated two central provisions of the law: the individual mandate and the mandatory Medicaid expansion. The Supreme Court held that the individual mandate, which requires most Americans to have health insurance or face an income tax penalty, was constitutional. The mandatory Medicaid expansion, however, was overturned and is now optional. Many states have chosen to opt out of expansion (The Advisory Board Company 2013).

The chart below highlights key provisions of the ACA that have important benefits for women.

AFFORDABLE CARE ACT KEY PROVISIONS FOR WOMEN

COVERAGE

- **State Health Exchanges:** virtual health insurance marketplaces operated at the state level
- **Expanded Medicaid Access:** state option to expand Medicaid to remaining low-income uninsured population
 - Up to 10 million women could benefit if all states expand
- **Young Adult Coverage:** individuals 26 and under can remain on a parent's insurance plan
 - An estimated 1.1 million young women affected
- **Choice of Physician:** women can see a primary care physician, including an obstetrician/gynecologist, in their health plan's network without a referral

AFFORDABILITY

- **Premium Tax Credits:** low- and moderate-income individuals will receive tax credits to offset the cost of insurance premiums for insurance plans purchased through state exchanges

CONSUMER PROTECTIONS

- **Gender Rating:** insurers prohibited from charging women more than men for the same insurance coverage
- **Pre-Existing Conditions:** pregnancy, cesarean-sections and domestic violence can no longer be used as a basis for limiting or denying women insurance coverage

BENEFITS

- **Essential Health Benefits:** individual and small group insurers must cover 10 categories of benefits, including maternity care, mental health and substance abuse treatment, and preventive care
 - 8.7 million women to gain maternity coverage
- **Preventive Services:** insurers must cover preventive services without cost-sharing, including eight women's health-specific services
 - 20.4 million women gain access to preventive services without cost-sharing

The ACA addresses women's health challenges and improves coverage, affordability, and access to health care for women. With the Supreme Court's decision to uphold the ACA and the 2012 Presidential election decided, various stakeholders are engaged in accelerated ACA implementation efforts, especially as the 2014 deadline for the establishment of health insurance exchanges rapidly approaches. While the federal government and states are focused on complex issues that need to be addressed to reform the U.S. health care system, philanthropy is uniquely situated to focus on and address the challenges specific to women's health.

WOMEN'S HEALTH CHALLENGES UNDER THE ACA

Across the lifespan, women in the United States face critical health care challenges. Before Congress passed the ACA in 2010, an estimated 18.7 million women lacked health insurance coverage (Robertson et al. 2012). Until this is rectified, many women are placed at high risk of not receiving the health care they need, which has implications for both quality of life and the costs of care resulting from poorer health outcomes associated with gaps in coverage (Robertson et al. 2012). This report outlines key women's health care challenges, ACA provisions that address these challenges, and opportunities for philanthropy to advance women's health and address remaining challenges as reform efforts intensify. It draws many insights from lessons learned from Massachusetts health reform.

WOMEN'S HEALTH PREVENTIVE SERVICES

THE CHALLENGES

Preventive care and early detection of diseases, which are often identified during well-woman visits and regular preventive care appointments, can lead to effective treatment and improved health outcomes. This is particularly important given that more than one-third of women have at least one chronic illness requiring ongoing treatment, and, compared with men, women are more likely to experience multiple chronic diseases (Ranji and Salganicoff 2011; Wood et al. 2009). Many experts agree that evidence-based clinical preventive services can improve population health and quality of life, often at little cost, and should be a key element of health reform strategies (Maciosek et al. 2010; CDC 2009; Goetzel 2009).

Despite the importance and cost-effectiveness of preventive care, more than half of American women are not up-to-date on recommended preventive services, often because of access issues and cost (Robertson and Collins 2011). Cost-sharing in the form of a copayment, coinsurance, or deductible has a negative impact on a woman's access to preventive care. This is a particular problem given that women live longer than men, experiencing higher rates of chronic disease and higher rates of utilization and spending for health care services as they age. The associated chronic illness costs for women are high, at an estimated \$466 billion in direct health care costs per year (Wood et al. 2009).

HOW DOES THE ACA ADDRESS THESE CHALLENGES?

The ACA requires insurers to cover a range of preventive care services for adults, women, children, and Medicare beneficiaries without cost-sharing. An additional eight women's health preventive services, recommended by an Institute of Medicine panel of women's health experts, and accepted by the U.S. Department of Health and Human Services (HHS), went into effect on August 1, 2012. These services are available without cost-sharing and include: well-woman visits; screenings for gestational diabetes; HPV DNA testing; counseling for sexually transmitted infections; counseling and screening for HIV; breastfeeding support, supplies, and counseling; screening and counseling for interpersonal and domestic violence; and Food and Drug Administration-approved contraceptive methods and contraceptive counseling. This provision, in addition to other adult preventive services such as mammograms and cervical cancer screenings, has resulted in an estimated 20.4 million women accessing preventive services without cost-sharing (The White House 2013).

The ACA also establishes new health insurance plans that must cover 10 essential health benefits, including preventive services, many of which will be provided without cost-sharing (ACA 2010a). Massachusetts' 2006 health reform program built upon existing state provisions that mandated coverage for certain preventive services. Mounting evidence from evaluations of the Massachusetts program suggests an increase in the utilization of preventive services, a decline in hospitalizations for preventable conditions, and an improvement in quality of care (Kolstad and Kowalski 2010). For the ACA, challenges remain in the monitoring and

implementation of the preventive services provision. There is anecdotal evidence that the lack of oversight and clear guidelines, including when a service transitions from preventive to diagnostic, has left many patients and providers confused about this provision (Bebinger 2011; Dennis et al. 2009).

WHAT ARE THE OPPORTUNITIES FOR PHILANTHROPY TO ADDRESS THESE CHALLENGES?

- ***Fund research projects and advocacy initiatives to evaluate and monitor access to and utilization of “no-cost” preventive services for women.*** Philanthropy can play a critical role to ensure that women are able to access the preventive services they are entitled to under health care reform through research and advocacy efforts to address the following potential challenges:
 - barriers to receiving preventive services without cost-sharing for certain subgroups of women, including those with certain types of insurance coverage or within certain types of service delivery systems;
 - women’s need for education about the preventive benefits they are entitled to under reform so that they can advocate for these services with their providers; and
 - implementation of the preventive service provision by insurers and providers, and the impact of this provision on access, utilization, cost, and quality of health care, especially for women with chronic illnesses and disabilities.
- ***Fund outreach and education campaigns and materials to educate stakeholders about the preventive services now available under the ACA.*** Not all women are aware of the preventive services available to them. Philanthropy can fund the development and dissemination of educational materials about these benefits for women and the providers who care for them. Educating providers and their staff about the new coverage options available without cost-sharing is particularly important because they serve as the gateway to these essential services. Coordinating funding efforts with the exchanges, where many of the newly insured will obtain coverage, will be crucial to make outreach and education campaigns successful.

ACCESS TO HEALTH INSURANCE COVERAGE

THE CHALLENGES

Health insurance coverage is an important factor in a woman’s ability to access necessary health care services. While the majority of U.S. women ages 18 to 64 (58 percent) receive insurance coverage through an employer, women are less likely to be insured by their own job and, instead, are more likely to be a dependent on a parent or spouse’s insurance plan (The Henry J. Kaiser Family Foundation 2012a). Nationally, 19 million women (20 percent) ages 18 to 64 are uninsured. Of those women, one in four are young women between the ages of 19 and 25, more than one-third are Latina (38 percent) and poor (39 percent), and one in four (28 percent) are single parents (The Henry J. Kaiser Family Foundation 2012a). Older women are also disproportionately uninsured, with 34 percent of women ages 45 to 64 lacking health insurance (based on 2011 Current Population Survey data). These women are at increased risk for chronic disease, pre-existing conditions, and disability, and many do not receive the preventive and mental health care they need. As a result, many enter Medicare as more difficult and expensive patients to treat (Prickett and Angel 2011).

Medicaid is the major provider of health insurance for low-income women who comprise nearly 70 percent of all Medicaid beneficiaries (Salganicoff and Ranji 2012). In addition, Medicaid beneficiaries are more likely to belong to a racial or ethnic group, have low levels of education, and report poor health (Musumeci 2012; Salganicoff and Ranji 2012). Because of strict categorical eligibility rules, the majority of Medicaid beneficiaries are pregnant women, parents with dependent children, disabled individuals, or individuals over the age of 65, all of whom must meet certain income requirements. This leaves a significant number of low-income individuals, most notably low-income adults who are not pregnant or do not have dependent children, without insurance coverage (CMS 2013a).

HOW DOES THE ACA ADDRESS THESE CHALLENGES?

The ACA's individual mandate, upheld as constitutional in the July 2012 Supreme Court decision, requires most people in the United States to have insurance coverage for themselves and their dependents by 2014. Primary coverage options include employer-sponsored insurance (ESI) plans, individual insurance plans purchased on the health insurance exchanges established by the ACA, Medicare plans, and Medicaid plans, among others (Musumeci 2012).

While all women benefit from improved health insurance coverage, young adult women under the age of 26 and low-income women will make significant gains. Young women can now access insurance coverage through their parents' insurance plans. Low-income women who are currently uninsured may also gain coverage through the ACA's Medicaid expansion if their state decides to participate.

- *Young Adult Women:* Prior to the ACA, insurance companies could remove children enrolled on a parent's insurance plan once they reached age 19, although some plans allowed children to remain on a parent's insurance plan while attending school full-time. The ACA now allows young adults ages 26 and under to remain on their parents' insurance plans. This provision has led to increased insurance rates for young people across the country, including 1.1 million young women (Broaddus and Park 2012; Cuellar et al. 2012). However, because private insurance plans routinely send policyholders (often a parent) an explanation of benefits (EOB)¹ after a beneficiary receives care, young women may forego sensitive services (for example, contraception, sexually transmitted infection testing, domestic violence counseling, mental health services, and substance abuse treatment) because of confidentiality concerns (Gold 2009; Slive and Cramer 2012).
- *Low-Income Women Who Do Not Meet Categorical Eligibility:* The ACA has the potential to expand Medicaid coverage to an estimated 10 million uninsured women, including 1.2 million near-elderly women (55 to 64), by covering most women with incomes below 138 percent of the federal poverty level (FPL) who are not pregnant or do not have dependent children (Salganicoff and Ranji 2012). The Supreme Court, however, ruled that expanded coverage to this new group of beneficiaries would remain optional for states. Thus, many of the 10 million women expected to gain insurance coverage will remain uninsured in states that opt out of the expansion (National Women's Law Center 2013).

Although the ACA is designed to provide insurance coverage for most low-income women through Medicaid eligibility and exchange subsidies, the experience from Massachusetts health care reform illustrates that even subgroups of women who may be eligible for coverage under reform remained uninsured. As of 2009, the majority of the approximately 60,000 women who remain uninsured in Massachusetts had incomes that would have qualified them for Medicaid or subsidized coverage. These women were more likely to be low-income, young, single, and Hispanic (Long et al. 2010). Further research is needed to understand why these women remain uninsured.

WHAT ARE THE OPPORTUNITIES FOR PHILANTHROPY TO ADDRESS THESE CHALLENGES?

- ***Fund studies that monitor the impact of Medicaid expansion programs.*** Philanthropy could fund research to examine the impact that a state's decision to expand or not expand its Medicaid program has on women, including health outcomes and insurance coverage.
- ***Fund advocacy and public service campaigns to encourage states to accept the expansion.*** Philanthropy could fund advocacy efforts to support Medicaid expansion across states to ensure that vulnerable populations of women, those most in need of coverage, are not left out of this historic opportunity to address disparities in coverage.

¹ EOBs usually include information about the patient, provider, type of care received, coverage amounts, and cost of care. For more information, see: Gold, R.B., "Unintended Consequences: How Insurance Processes Inadvertently Abrogate Patient Confidentiality," *Guttmacher Policy Review* 12(4):12-16.

- ***Fund safety net and pilot programs that provide alternative models of coverage for low-income women in states that do not expand Medicaid.*** Philanthropy has an opportunity to provide much-needed funding to safety net and pilot programs to address uninsurance among populations of women excluded from Medicaid expansion. These efforts are particularly beneficial for undocumented immigrant women who will not gain access to coverage under the ACA.
- ***Fund culturally competent outreach and enrollment efforts supported by comprehensive demographic data on the uninsured.*** Philanthropy has a unique opportunity to fund local outreach and enrollment initiatives that are culturally competent and to utilize community workers and stakeholders to maximize coverage among low-income women. The ACA will bring a new set of eligibility and administrative requirements for Medicaid applicants and enrollees and for people eligible for subsidized coverage through state exchanges. Well-informed, culturally and linguistically competent outreach workers, who can explain new rules and help navigate an unfamiliar system, will be invaluable in maintaining and expanding coverage. To further support these efforts, funding the collection of stratified data will be essential in identifying which subgroups of women need assistance and why some women who qualify for subsidized coverage remain uninsured.
- ***Fund advocacy to ensure that young women can access confidential services, including reproductive and sexual health services.*** Funders can support advocacy efforts to work with lawmakers, regulators, and insurers to balance the need for confidential access to services with the need for a comprehensive EOB. To ensure that women have access to the full spectrum of health services that they are entitled to under the ACA, funders could support advocacy efforts aimed at identifying and resolving such barriers to care.

CHURN AND GAPS IN COVERAGE

THE CHALLENGES

The complexity and structure of the ACA's multipayer, multimarket approach to insurance coverage have raised new issues for some low-income women as shifts in income eligibility result in frequent transitions between insurance options (for example, Medicaid, subsidized and unsubsidized exchange plans), sometimes referred to as "churn" (Rosenbaum 2011). Women are disproportionately affected by churn for the following reasons:

- Women are more likely than men to cycle in and out of the workforce and are less likely to be eligible for employer-sponsored health insurance, resulting in fragmented coverage.
- Women are more likely to have fluctuations in income, a key factor in determining insurance eligibility.
- Women are more likely to be dependents on someone else's health insurance plan. Research has found that there is a strong link between a woman's likelihood of having health insurance and her marital status (Wyn and Peckham 2010). Yet coverage for dependents is inherently less stable since continuity depends on the partner's continued employment, the employer's decision to continue offering dependent coverage, and the dependent's ongoing relationship with the covered partner (Patchias and Waxman 2007).
- Life events, such as pregnancy, marriage, divorce, and death of a spouse, affect health insurance eligibility.

In Massachusetts, a significant number of low-income residents churn between Medicaid and subsidized insurance plans because of income fluctuations and changes in eligibility status over the course of the year. Approximately 17 percent of these enrollees experienced a gap in coverage during their transition (Seifert et al. 2010). Given that women comprise the majority of nonelderly Medicaid enrollees in Massachusetts and a higher percentage of women are enrolled in subsidized insurance plans, it is highly likely that women comprise the majority of those at risk of churning between programs and experiencing gaps in coverage (Sered 2008; Turnball 2010).

Churn has negative impacts on health care quality and outcomes in the form of breaks in treatment,

redundant testing, lack of follow-up care, poor chronic disease management, and disruptive medication changes (Sered and Proulx 2011). This places a heavy burden on women who require ongoing treatment for chronic diseases or regular access to contraception, as well as during critical life stages such as adolescence, pregnancy, and menopause. Individuals with discontinuous coverage are less likely to have a usual source of care and are more likely to report delaying care due to cost (Lavarreda et al. 2008).

Churn is costly not only for individuals' health care quality and outcomes, but also for states, health plans, and health care providers. Conservative estimates in 2010 peg administrative expenses associated with enrollment at \$198 per person per enrollment in Massachusetts, which can translate to millions of dollars over the course of a year as participants lose coverage and are subsequently re-enrolled (Seifert et al. 2010; Seifert 2011).

HOW DOES THE ACA ADDRESS THESE CHALLENGES?

Some ACA provisions aim to reduce gaps in coverage among certain subpopulations. For instance, the ACA provides states with the option to establish a Basic Health Plan (BHP) for middle-income individuals who are ineligible for Medicaid (ACA 2010b). BHPs maintain coverage continuity and reduce churn within the exchanges by acting as an intermediary between Medicaid and the lowest-tiered subsidized plan under the exchange (Bachrach et al. 2012). Unfortunately, HHS has not issued regulatory guidance for BHP creation and implementation, leaving greater potential for gaps in coverage and churn as states are unable to implement this provision.

Additionally, the "no wrong door" provision improves the enrollment process by allowing consumers to submit one application for multiple insurance coverage programs (for example, Medicaid and subsidized and unsubsidized exchange plans). The exchanges will use this single application to determine eligibility for health insurance programs and premium tax credits (Morrow and Paradise 2010). Designing exchanges with a streamlined application process ensures continuous coverage and reduces gaps in coverage associated with complex application and enrollment procedures (Rodman 2012).

Enrollment volatility will likely affect national health reform. In 2014, 28 million Americans under 200 percent above the FPL are expected to experience a shift in eligibility between Medicaid and subsidized plans. Women comprise the majority of nonelderly Medicaid enrollees, and a higher percentage of women than men have enrolled in subsidized insurance plans, suggesting that the largest percentage of those at risk of transitioning between insurance programs and experiencing coverage gaps are women (Sered 2008; Turnball 2010).

WHAT ARE THE OPPORTUNITIES FOR PHILANTHROPY TO ADDRESS THESE CHALLENGES?

- ***Fund advocacy programs designed to help reduce churn and gaps in coverage.*** Philanthropy could fund advocacy efforts that monitor whether the exchanges are implementing the ACA's provisions for streamlined enrollment options. Additionally, advocacy efforts are needed to ensure that women receive appropriate information and education about their health insurance options and administrative requirements in order to maintain consistent coverage.
- ***Fund studies and programs to monitor and address churn and gaps in coverage for women.*** Philanthropy can fund programs and studies that analyze important aspects of churn and gaps in coverage, including the impact of churn on women's health outcomes and state costs. Additionally, funders can work with states to ensure that they have proper mechanisms in place to plan for and address administrative challenges associated with churn, especially in light of the states' inability to implement a BHP.
- ***Fund pilot studies to examine the efficacy of models designed to reduce churn.*** Advocacy groups have developed best practice models to address the issue of churn in the new health care insurance exchanges. Philanthropy could fund studies to evaluate the efficacy of these models in states interested in addressing this important issue (Rodman 2012).

AFFORDABILITY

THE CHALLENGES

Women tend to require and utilize more health care services than men, primarily because of their reproductive health care needs, higher rates of chronic illness and disability, and longer life expectancies. As a result, they are disproportionately affected by health care costs, not only because of higher overall medical expenditures, but also because, compared to men, their out-of-pocket medical expenses are higher, while their lifetime earnings are lower (Patchias and Waxman 2007). Financial barriers to care can affect women with insurance, as well as those who are uninsured, and can come in the form of premiums, cost-sharing charges for specific services, and limits on a plan's benefit package. A large body of research finds that even a small amount of cost-sharing can negatively impact a woman's ability to afford and access care, sometimes resulting in even higher downstream costs because of lower use of preventive or treatment services (Swartz 2011; Robertson and Collins 2011).

Issues with affordability are apparent in Massachusetts, where the share of women spending 5 percent or more of family income on out-of-pocket health care costs did not change significantly between 2006, when state health reform was first implemented, and 2009. Similarly, the share of women reporting problems paying medical bills or paying medical debt over time did not decrease after state health reform (Long et al. 2010). Nationally, 43 percent of women reported in 2010 that at least once within the past year they did not pursue recommended care, went without a doctor's visit when sick, or skipped filling drug prescriptions because of cost (Robertson et al. 2012). Certain groups of women may have particular difficulty affording care. These include:

- women with incomes just above the threshold of eligibility for subsidized health insurance;
- women choosing low-premium, high-deductible health plans;
- women enrolled in catastrophic coverage;
- women ages 50-64, who have increasing health problems but are not yet eligible for Medicare;
- women with incomes between 200-400 percent of the FPL who do not have the highest levels of premium or cost-sharing subsidies; and
- women who previously received care at little or no cost through safety net programs.

While Massachusetts established its own exchange in 2006, affordability remains a challenge for women today, despite the availability of a range of health insurance plans. Women's greater health needs and the general unpredictability of health events make choosing the most affordable coverage particularly challenging for women who do not meet the income eligibility requirements for subsidized plans. This is because some women may choose a plan based on premium cost alone, unaware that the accumulation of out-of-pocket costs (that is, deductibles, coinsurance, and copayments) can make lower premium plans more expensive in the long run. This is particularly problematic for women who make frequent physician visits for necessary care, such as reproductive care or chronic health conditions.

HOW DOES THE ACA ADDRESS THESE CHALLENGES?

The ACA requires states to establish a health insurance exchange, a marketplace where women and their families can purchase affordable insurance options if they do not receive coverage through their employer, Medicaid, or Medicare (ACA 2010c). Exchanges will allow individuals to compare health plan options, quality, and price; determine eligibility for tax credits and Medicaid; and enroll in a health plan through an Internet-based system. Consumers can also receive answers to questions from a toll-free hotline or utilize a cost calculator to help determine costs after subsidies are calculated.

Additionally, the ACA allows for the establishment of a "navigator program" to help consumers navigate the

insurance enrollment process, including determining which subsidies they may qualify for under the law, in a “culturally and linguistically appropriate manner” (ACA 2010d). Given that there is no commitment in the ACA language requiring states to include sex as a factor in the development of these consumer resources, states may not consider the factors listed above that make insurance affordability problematic for women.

The ACA addresses the issue of insurance coverage affordability by offering tax credits based on income level to help low-income individuals between 138 and 400 percent of the FPL pay for insurance plans purchased through an insurance exchange. These subsidies will be particularly beneficial for women, who are more likely to qualify for subsidies because of lower incomes. Additionally, some individuals purchasing coverage through the exchange will also receive cost-sharing reductions to alleviate their out-of-pocket costs (ACA 2010e; The Henry J. Kaiser Family Foundation 2012b).

The ACA also addresses affordability for ESI coverage for low- and moderate-income individuals by offering federal subsidies when ESI is deemed unaffordable. The ACA defines ESI as “affordable” when an ESI’s premium costs are less than 9.5 percent of an individual’s household income (Gruber and Perry 2011). This definition of affordability is problematic, however, because the ACA ties eligibility for premium tax credits for working families to the annual cost of an individual plan, not a family plan. This means that many families will not receive federal subsidies even though their ESI family plan is unaffordable. Many of these families may forgo insurance altogether and pay the tax penalty the ACA imposes on individuals who remain uninsured.

WHAT ARE THE OPPORTUNITIES FOR PHILANTHROPY TO ADDRESS THESE CHALLENGES?

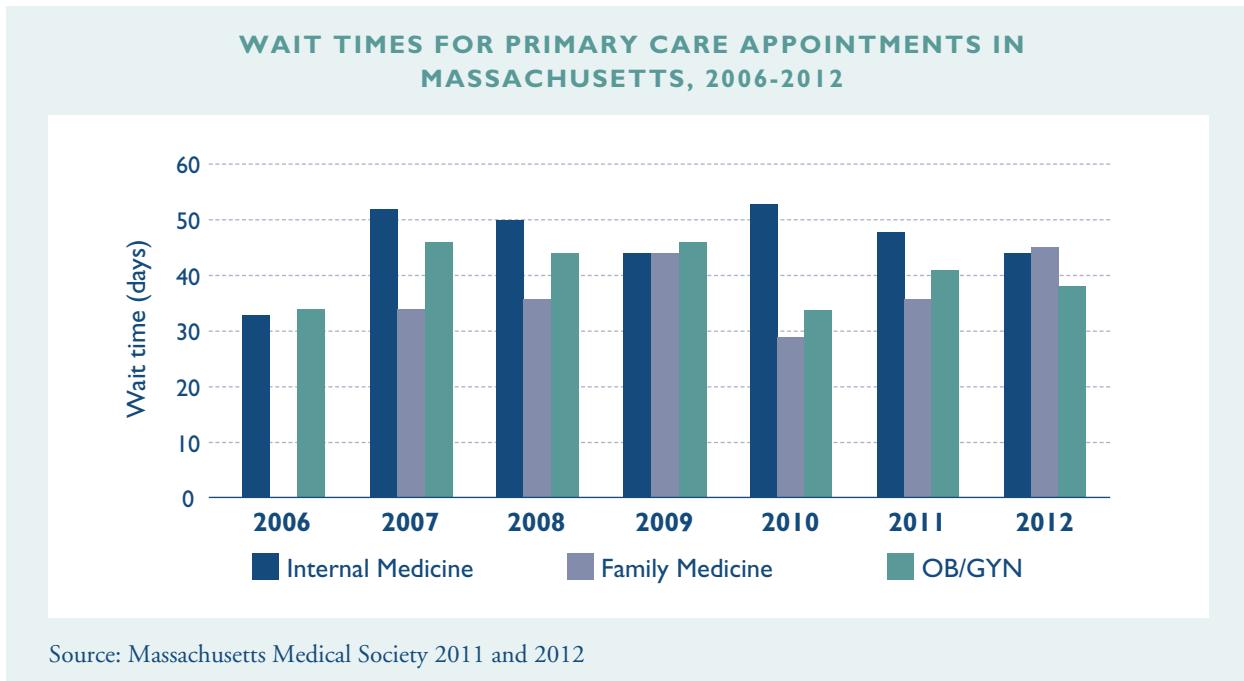
- ***Fund research to examine if the subsidies are generous enough for women to afford care from the exchanges.*** By funding research to monitor whether women are able to access care even with expanded coverage and income-based subsidies, important questions related to affordability and uninsurance can be answered.
- ***Fund research to determine if families with “affordable” ESI are accessing coverage.*** Philanthropy could fund studies to determine if low- and moderate-income families are forgoing insurance coverage because of cost associated with unaffordable plans.
- ***Fund the development of and advocacy for comprehensive, consumer affordability tools designed with the needs of women in mind.*** Philanthropy has an opportunity to address women’s particular affordability concerns by providing supplemental funds to tailor state consumer affordability tools to meet the needs of women. For example, funders could give states funding to develop cost calculators that include questions about sex, chronic disease, and reproductive and mental health. Funders could also support advocacy efforts to build support for these important tools among state legislators and government officials.

PRIMARY CARE

THE CHALLENGES

Primary health care, including family medicine, internal medicine, obstetrics and gynecology, geriatrics, and psychiatry, is integral to a woman’s health (Mann et al. 2010). Because of women’s reproductive health care needs, higher rates of chronic illnesses and disabilities, vulnerability to certain mental illnesses such as depression, and longer life expectancies compared to men, primary care is essential to maintaining a woman’s health throughout her life (SAMHSA 2012; NCHS 2001). Researchers estimate, however, that there will be a shortage of 45,000 primary care providers (PCPs) by 2020 (National Women’s Law Center 2012). Currently it is estimated that 7 million people in the United States reside in areas where demand for primary care services will exceed supply by over 10 percent (Long et al. 2010).

With 17 million women estimated to gain access to health insurance coverage by 2014, primary care short-



Source: Massachusetts Medical Society 2011 and 2012

ages are a crucial issue to address from a women's health perspective (National Women's Law Center 2012). For example, although Massachusetts health care reform provided women with improved access to primary care services, studies indicate that workforce shortages persist and wait times are long, as illustrated in the chart above (Long et al. 2010; Massachusetts Medical Society 2012).

HOW DOES THE ACA ADDRESS THESE CHALLENGES?

The ACA addresses recruitment, retention, and training of PCPs by providing payment bonuses for PCPs practicing in community settings or areas with health shortages, and grants to create or expand primary care residency programs at teaching health centers (ACA 2010f). The ACA also increases payment rates to PCPs who care for Medicaid beneficiaries, recognizing that low reimbursement rates have been a deterrent for many providers to treat this population (Salganicoff and Ranji 2012). These raises, however, are temporary and may not alleviate the PCP shortages expected with the influx of the newly insured into the health care system (Salganicoff and Ranji 2012). Additionally, the ACA establishes the National Health Care Workforce Commission, an independent body that will address shortages in the health care workforce, including PCPs, by administering workforce grants, monitoring education and training, and coordinating initiatives to improve access to health care (ACA 2010g). Other efforts, however, may be necessary to ensure that PCP shortages are addressed as the population ages and insurance coverage expands under the ACA (Green et al. 2013; Center for American Progress 2009).

WHAT ARE THE OPPORTUNITIES FOR PHILANTHROPY TO ADDRESS THESE CHALLENGES?

- ***Develop public-private partnerships to address workforce shortages.*** Philanthropy could establish new public-private partnerships or support existing initiatives² to address workforce shortages through loan repayment programs, physician retention efforts, or incentives for physicians practicing in underserved areas. Funders could also collaborate with state agencies, which are uniquely positioned to address the needs of their local health care areas.

² Examples include the [Massachusetts Community Health Center Primary Care Provider Loan Repayment Program](#) and the Kraft Center for Community Health.

- ***Support research on flexible work arrangements for PCPs.*** Flexible schedules can alleviate some of the stress of primary care patient loads, retaining practitioners for longer periods of time and providing an incentive for physicians entering several primary care fields. There is currently little research on how best to develop these flexible work arrangements. Given the increasing proportion of PCPs who are women, and the demands of family and caregiving that fall disproportionately on women, developing new models of work is an important component to attracting and retaining physicians and other care providers.
- ***Fund primary care workforce studies and research on the issues driving primary care workforce shortages.*** Without adequate longitudinal data at both the state and federal levels, policymakers cannot adequately address shortages. Therefore, monitoring primary care workforce trends will be essential in identifying the most critical areas of need in the country. Research should include shortages in specialties important to women's health; geographic shortages; and the roles of non-physician providers, including nurse practitioners, physician assistants, social workers, care coordinators, dieticians, pharmacists, and therapists, in primary care (Rosenthal 2008). Further, it is essential that these studies go beyond simple physician-to-patient ratio estimates to examine factors associated with PCP supply and demand, including changing patient demographics, alternative models of care delivery, new provider payment structures, and health information technology (Green et al. 2013).

LONG-TERM CARE

THE CHALLENGES

Women with chronic disease and disability rely on long-term care (LTC) services to meet their health care needs over the long term. LTC affects women as both patients and providers. As patients, women utilize LTC services more frequently than men do because they live longer and are more likely to have multiple chronic conditions. In addition, women are more likely to populate the professions responsible for LTC, as well as serve as unpaid informal caregivers for family members and friends. LTC needs are not limited to elderly women. In fact, more than one-third of individuals who need LTC services are under age 65, the majority of them being women (Rogers and Komisar 2003).

Over 43.5 million American adults, most of whom are women holding full-time or part-time jobs, are unpaid caregivers to older adults (National Alliance for Caregiving and AARP 2009). Providing uncompensated care affects the health and economic well-being of female caregivers. For example, studies have shown that providing caregiving services for a disabled or ill family member is associated with increased risk of depressive and anxious symptoms and coronary heart disease in women (Cannuscio et al. 2002; Lee et al. 2003). Additionally, informal caregivers are not only inadequately compensated, but they are often required to reduce work hours or give up employment altogether. Lost productivity costs U.S. businesses tens of billions of dollars annually, while the value of informal caregiving is estimated to be between \$148 and \$188 billion annually (Family Caregiver Alliance 2003).

HOW DOES THE ACA ADDRESS THESE CHALLENGES?

The ACA funds several LTC demonstration programs aimed at strengthening the formal LTC workforce through training and loan forgiveness (HHS 2011). In addition, the law provides funding for new models of care to better address the needs of the LTC population, including efforts to transition care to outpatient and community settings, and improve care coordination for those with multiple chronic conditions and persistent mental illness (CMS 2013b; Townley and Takach 2012).

The Community Living Assistance Services and Support Act (CLASS Act) was a major attempt at addressing LTC issues through the creation of a voluntary LTC insurance program (ACA 2010h). The CLASS Act would have provided a cash benefit to fund care, including payments to informal caregivers. While Congress repealed the program in early 2013, deeming it to be financially unsustainable, a new federal LTC commission was created post-repeal to develop a comprehensive plan to address the country's LTC needs (American Tax Payer Relief Act 2012).

Finally, although the ACA prevents health insurers from gender-rating insurance plans (that is, charging women more than men for the same coverage), the law does not prohibit LTC insurers from gender rating, leaving women at a disadvantage when it comes to accessing affordable coverage options. For example, one of the largest LTC insurers in the United States has plans to set prices based on sex, which will result in an estimated 20 to 40 percent increase in women's premiums (Andrews 2013).

WHAT ARE THE OPPORTUNITIES FOR PHILANTHROPY TO ADDRESS THESE CHALLENGES?

- ***Fund public-private strategic planning initiatives.*** Philanthropy could fund coordinated, multistakeholder strategic planning initiatives at the state level. Engagement across groups will be essential to finding workable solutions and should include both government and private entities.
- ***Fund advocacy to improve LTC for women.*** Philanthropy could fund advocacy efforts and initiatives aimed at ensuring that the LTC needs of women, as both patients and caregivers, are being met across the lifespan under the ACA at the federal and state levels. For example, philanthropy could fund advocacy for state laws prohibiting gender rating in all forms of insurance.
- ***Improve LTC financing mechanisms.*** Philanthropy could explore funding for new financing strategies to address LTC issues, including new private insurance products that link life insurance and LTC insurance, and social insurance model approaches similar to Social Security to incentivize individuals to save for LTC (UMASS 2010).
- ***Support programs for informal caregivers.*** Even small amounts of funding for managing stress and improving self-care can make a difference in the lives of informal caregivers in need of support. Philanthropy could also connect with local area agencies under the National Family Caregiver Support Program (Title IIIIE of the Older Americans Act) to provide information, assistance, counseling, support, and training programs and respite to caregivers (UMASS 2010). Philanthropy can also provide funding to study the outcomes of these models on women's health.
- ***Fund LTC data needs.*** Philanthropy could provide funding to fill the gaps in data and research associated with LTC, including data on the populations in need of services, unmet care needs, spending and utilization trends, programs that integrate care management, acute and LTC financing, delivery of care, and successful programs that provide support to unpaid caregivers (UMASS 2010).

WOMEN'S HEALTH RESEARCH: DATA COLLECTION, STRATIFICATION, AND ROUTINE REPORTING

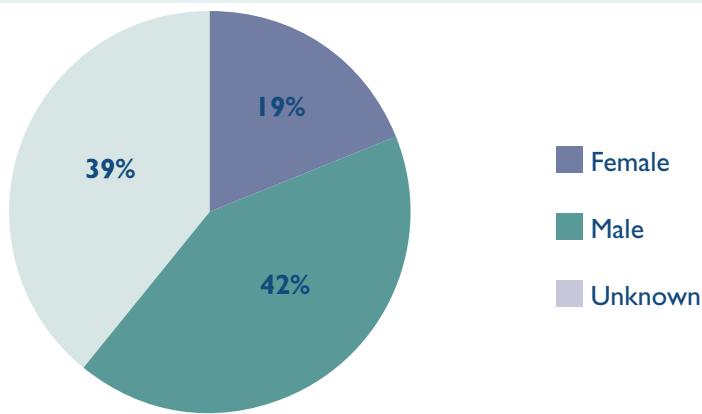
THE CHALLENGES

Robust data collection and reporting standards are essential to understand the impact of important ACA provisions. Health policy experts and researchers, however, are concerned that, without a specific commitment to collect and routinely report sex- and population-specific data, the impact of the ACA on certain underserved subgroups (including women; racial and ethnic groups; the lesbian, gay, bisexual, transgender and questioning community; persons with disabilities; non-English speaking individuals; and low-income groups) will not be properly documented, analyzed, and addressed. For example, Massachusetts does not require this commitment (Massachusetts Health Connector 2012). As a result, the sex of over one-third of uninsured tax filers in Massachusetts is unknown, making it difficult to provide targeted outreach and enrollment services to uninsured men and women in the Commonwealth.

HOW DOES THE ACA ADDRESS THESE CHALLENGES?

The ACA requires federally conducted or supported health care or public health programs, activities, or surveys to create standards for collecting and publicly reporting self-reported data on sex, race, ethnicity, primary language, and disability status to the extent practicable. This caveat leaves the provision open to

**FULL-YEAR UNINSURED MASSACHUSETTS RESIDENTS
BY GENDER, 2010 (N=170,000)**



Source: Massachusetts Health Connector 2012

interpretation and may not ensure the routine stratification, analysis, and reporting necessary to ensure that health disparities are addressed under reform.

WHAT ARE THE OPPORTUNITIES FOR PHILANTHROPY TO ADDRESS THESE CHALLENGES?

► ***Fund research studies that examine the impact of the ACA on women and subgroups of women.***

Philanthropy could provide funding to support new survey research or improvements to existing surveys. Analysis should include a focus on women's health care access, utilization, coverage, cost, and affordability. Examples of important data to collect and stratify include:

- out-of-pocket medical spending in addition to premium costs in order to develop robust affordability standards;
- measurement of the frequency and impact of transitions between coverage categories, such as subsidized exchange plans and Medicaid, so that insurance plans can be designed to reduce the likelihood of gaps in coverage;
- use of Internal Revenue Service data in order to understand which groups are most likely to remain uninsured after the individual mandate goes into effect in 2014;
- comprehensive data on health status and measurement of access to health services and utilization in order to understand the impact of the ACA on health outcomes and cost; and
- stratification by demographic characteristics, such as age, race/ethnicity, insurance type, and health status.

► ***Report on stratified data.*** Require grantees conducting research on the ACA to include women and subgroups of women in their research studies and to report on sex-specific data as a condition of funding.

CONCLUSION

In addition to the recommendations presented above, philanthropy can maximize the efficiency of its investments in women's health under reform in the following ways:

- **Coordinated Funding:** Coordinate funding initiatives with public and private partners to maximize resources and avoid duplication of effort. For example, philanthropy could work with other philanthropic organizations and state public health departments to monitor implementation of the no-cost preventive services for women.
- **Gender-Focused Lens:** Adding a gender focus or lens to the work funders are currently supporting is another example of how philanthropy can maximize its investments in women's health. An example would be adding a women's health focus to an existing primary care project to support flexible schedules for female physicians.
- **Advocacy:** Fund advocacy efforts that keep women's health at the forefront of health care implementation. Given the highly technical nature of the ACA's provisions, important decisions are being made at the state and federal levels to address complex issues such as exchange design and rating reforms. Philanthropy can support women's advocacy and consumer advocacy organizations to participate in all aspects of policy and implementation decisions being made under the ACA, particularly in states lacking strong consumer and women's advocacy groups.
- **Comprehensive Data:** No matter what types of projects philanthropy chooses to fund, effective women's health policy depends on the collection, analysis, and reporting of health reform data by sex and sex/race groups, an untapped area of philanthropy where funders of all capacities can make a significant impact.

The ACA is one of the most significant women's health advances in U.S. history. Millions of women will gain access to comprehensive, affordable health insurance coverage that meets all of the care a woman needs across her lifespan. Given Massachusetts' experience with health reform, however, we know that important challenges will persist despite reform efforts. State and federal governments are working at full capacity to prepare the country for health reform in an environment marked by significant budget restraints and increasing pressure to control costs. By investing in women's health under health care reform, philanthropy will ensure that the promise of this historic law, despite the challenges ahead, will become a reality.

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ACKNOWLEDGMENTS

The report is authored by **Paula A. Johnson, M.D., M.P.H.**, executive director of the Connors Center for Women's Health and Gender Biology and chief of the Division of Women's Health at Brigham and Women's Hospital; **Therese Fitzgerald, Ph.D., M.S.W.**, director, and **Laura Cohen**, senior health policy analyst, of the Women's Health Policy and Advocacy Program, Connors Center for Women's Health and Gender Biology at Brigham and Women's Hospital. The mission of the Women's Health Policy and Advocacy Program is to inform and advance policy at all levels—local, state, and national—to promote the highest standard of health and health care for all women. Special thanks to **Carolyn Luk** for her assistance in researching, editing, and formatting this report.

Opportunities to Maximize Women's Health Under the Affordable Care Act was made possible by funding from The California Wellness Foundation. The following individuals provided invaluable suggestions and comments in preparing the report.

- **Faith Mitchell, Ph.D.**, President and CEO, Grantmakers In Health
- **Kristen Barnicle**, Director, Community Health, Partners HealthCare
- **Julia Dyck, M.P.A., M.P.H., M.A.**, Director, Massachusetts Primary Care Office, Health Care Workforce Center, Massachusetts Department of Public Health
- **Karen Edlund, R.N.**, Director, Family Planning Program, Massachusetts Department of Public Health
- **Ann L. Hartstein, M.S., M.M.H.S.**, Secretary, Executive Office of Elder Affairs, Commonwealth of Massachusetts
- **Sharon K. Long, Ph.D.**, Senior Fellow, The Urban Institute
- **Jean Flatley McGuire, Ph.D.**, Professor of Practice, Health Sciences Department, Northeastern University
- **Alina Salganicoff, Ph.D.**, Vice President and Director, Women's Health Policy, The Henry J. Kaiser Family Foundation
- **Robert Seifert, M.P.A.**, Principal Associate, Center for Health Law and Economics, University of Massachusetts Medical School
- **Kim Simonian, M.P.H.**, Associate Director for Public Payer Patient Access, Partners HealthCare-Community Health
- **Nancy Turnbull, M.B.A.**, Associate Dean for Educational Programs, Harvard School of Public Health

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