Due to the passage of the Affordable Care Act (ACA), the uninsured rates among all groups of women fell dramatically. Per the Kaiser Family Foundation (KFF), between 2013 and 2015 the uninsured rates for all women fell from 17% to 11%, with rates for women <200% of the Federal Poverty Level (FPL) falling from 31% to 22%, single mothers falling from 24% to 16% and Hispanics falling from 31% to 20%. The number of women who delayed care has also fallen among women ages 18-64, from 13% in 2011 to 9% in 2015 (KFF). Further, the number of women who did not get care due to costs has fallen, for example prescription drugs from 12% in 2011 to 8% in 2015 (KFF). Medicaid expansion under the ACA as well as federal tax credits and cost sharing subsidies played a pivotal role in the increase in health care coverage for women.

Proposed changes to the ACA under the American Health Care Act (AHCA) have a disproportionate impact on the Medicaid population, by cutting $880B in funding. Women comprise the majority of Medicaid beneficiaries, as they are more likely than men to be low-income or poor due to the fact that they are more commonly head of a single parent household, work part-year or part-time, are paid less for similar work, or stay home to care for children or aging parents (KFF). Medicaid covers nearly 1 in 5 women (1 in 4 Latinas and African American women), pays for half of the births and . of all public family planning (KFF). In Arizona, 20-30% of women were on Medicaid in 2015 (KFF).

Under the AHCA, the federal funds for the ACA's Medicaid expansion are eliminated and a spending cap is instituted. 31 states and DC have expanded Medicaid under the ACA for those up to 138% FPL, with the federal government paying 95% of the cost (KFF). The AHCA would withdraw the enhanced federal funds for Medicaid expansion except for those enrolled as of 12/31/19 (grandfathered) who did not have a gap in eligibility for more than 1 month (KFF). As a result, the Congressional Budget Office (CBO) estimates that some states would not continue their expanded Medicaid coverage and that no new states would adopt the Medicaid expansion. The eligibility requirements would likely return to levels seen prior to the ACA, with many states income eligibility levels set significantly below the FPL (KFF). As discussed previously, due to the fact that women make up the majority of Medicaid enrollees, they will suffer the greatest impact by these cuts to Medicaid.

Subsides and credits are currently provided by the ACA to those with low income, seniors, and to those in areas with more expensive coverage. Under the ACA, premium tax credits are granted to those with incomes between 100-400% FPL (81% of Marketplace beneficiaries) and cost sharing subsidies are given to eligible individuals between 100-250% FPL (KFF). The AHCA eliminates the cost-sharing subsidies as of 1/1/20 and provides a flat tax credit based only on age, up to an income of $75,000, which would decrease aid to older and low income

Marketplace enrollees (KFF). Because women are more likely to be low income, they will be affected by these changes to a greater extent.

Under the AHCA, federal Medicaid payments to Planned Parenthood (PP) would be prohibited for 1 year. A recent opinion poll shows that 75% of Americans favor continued federal funding for PP (KFF). Currently PP receives approximately $500M yearly in federal support by providing care to Medicaid patients as well as grant funds from the federal Title X family planning program. PP provides essential services to 2.5M patients each year, not only providing contraceptives but also sexually transmitted infection and cancer screenings. Under AHCA, defunding PP would result in almost 400,000 women losing access to preventative care and up to 650,000 having reduced preventative care according to an estimate from the Government Accountability Office (GAO). PP made up only 6% of the safety-net clinics providing family planning services in 2015, but served 32% of women who sought contraceptive care at those centers (KFF). This compares to

federally qualified health centers which comprise 54% of clinics but saw only 30% of contraceptive clients (KFF). Community Health Centers would be given additional funds under the AHCA, but with no requirement to spend them on women's services, and no current capacity to fill the gap left by PP (KFF). A study from the Washington University School of Medicine has shown that access to free birth control significantly lowers rates of unintended teen pregnancy and abortion.

No cost contraceptive coverage is provided under the ACA to the majority of women with private insurance, including all FDA-approved contraceptive methods. Due to the ACA, the share of women paying any out-of-pocket cost on oral contraceptives fell from 20.9% in 2012 to 3% in 2015 (KFF). Currently "exemptions" to coverage are reserved for a house of worship only, in which case the employer is not required to cover contraceptives and employees and dependents do not have guaranteed coverage (KFF). "Accommodations" are granted to religiously affiliated nonprofit and closely held for-profit corporations where an employer must notify HHS, the insurer or third party administrator (TPA) of the religious objection to contraception (KFF). In these cases, the employer is not obligated to purchase contraceptive coverage, but the insurer or TPA must pay for coverage for workers or dependents. The AHCA does not specifically address contraceptive coverage, but President Trump's Executive Order Promoting Free Speech and Religious Liberty called on the Secretaries of Labor, Treasury and Health and Human Services to amend regulations to protect conscience-based objections, with the goal of "exempting" (rather than "accommodating") any employer with a religious or moral objection from the contraceptive coverage requirement (KFF). If this were to occur, contraceptive coverage would once again be decided by employers, insurance plans and state policy (KFF).

One of the big successes of the ACA was prohibiting the ability of insurers to deny coverage based on pre-existing conditions (guaranteed issue). This is particularly important for women, as pre-existing conditions can include pregnancy, prior C-section, sexual assault, domestic violence, breast cancer, and postpartum depression. 32% of mothers have had a C-section, 1 in 6 women are victims of sexual assault, and 30% have experienced some form of domestic abuse (Farber). The AHCA maintains the ban but if there is a gap in coverage of 63 days or more in the preceding 12 months, the AHCA allows insurers to charge 30% higher premiums for 1 year or allows states to request a waiver to allow insurers to medically underwrite (charge a higher rate for pre-existing conditions) for 1 year (KFF). So, while insurers cannot deny coverage, they can raise rates so that individuals with pre-existing conditions can no longer afford coverage. The ACA requires all plans in the Marketplace as well as the Medicaid expansion programs to cover 10 categories of Essential Health Benefits (EHB's). According to the Center on Budget and Policy Priorities, prior to the ACA, 62% of individual market consumers had plans that didn't cover maternity care, 18% had plans that didn't cover mental health treatment, 34% had plans that didn't cover substance abuse treatment, and 9% had plans that didn't cover prescription drugs. Particular victories of the ACA for women's EHB's were the inclusion of maternity and newborn care, preventive services, no-cost prenatal screening, breastfeeding supports, prescription drugs, and mental health. The AHCA repeals the EHB requirements for the Medicaid expansion programs, such that states could opt out of some of the EHB categories including substance abuse treatment and prescription drugs (KFF).

The AHCA also allows states to apply for a waiver to define their own EHB's for the individual and small group health insurance markets beginning in 2020 (the MacArthur Amendment). This would allow states to exclude any of the current EHB's from coverage, potentially allowing states to remove or scale back maternity services (KFF). Larger employers with employees in multiple states could then choose to adopt the EHB definitions of a state that does not include maternity benefits as it's EHB for employees in all states.

An additional advantage of the ACA Medicaid expansion is that it currently provides a pathway to coverage for postpartum mothers. By defunding the Medicaid expansion, some postpartum mothers would lose coverage once the 60-day postpartum period ends and would become uninsured (Health Reform Tracker (HRT)). The Manager's Amendment has a Medicaid work requirement which would allow states to revoke Medicaid coverage from new mothers who haven't found a job within 2 months after giving birth (HRT).

The ACA requires all private plans, Medicaid expansion programs and Medicare to cover preventive services without cost sharing, including all of the services recommended by the U.S. Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and services recommended by the Health Resources and Services Administration (KFF). Covered are such services as breast and cervical cancer screening, osteoporosis screening, pregnancy related services (breastfeeding counseling and equipment rental, folic acid supplements, tobacco cessation, alcohol misuse), well woman visits, contraception, interpersonal and domestic violence screening and counseling. The AHCA maintains the preventive services requirement for private plans but repeals them for the Medicaid expansion population (KFF). This allows states the option to eliminate these critical services for low income women.

Both the ACA and the proposed AHCA will maintain dependent coverage up to age 26 and ban the practice of gender rating (charging women higher premiums than men).

Despite the current Congressional agenda, there is majority support for the ACA's women's health provisions per a Kaiser Family Foundation poll in March of 2017. 95% believe private health insurance companies cannot be allowed to deny coverage to pregnant women. 95% believe private health plans must cover mammograms and cervical cancer screenings with no out-of-pocket costs. 93% believe private health insurance companies should not charge women more than men for the same policy. 78% believe private health plans must cover the costs of birth control with no out-of-pocket costs. 83% believe the federal government should provide funding for reproductive health services, such as birth control and family planning, for lower income women. While the ACA's coverage isn't perfect, it does a much better job of covering the scope and breadth women's health needs than the proposed AHCA. Instituting the AHCA has the potential to seriously limit women's care and roll back the positive gains achieved under the ACA.

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