



☞ August 2010 ☜

“Women are the foundation of many families, and by encouraging their wellness, we also promote the vitality of our children and our communities. By standing firm in our commitment to improve women’s health, we can give our daughters and granddaughters and all Americans a brighter future.”

- President Obama, Presidential Proclamation of National Women’s Health Week, May 7, 2010

INTRODUCTION

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law.¹ This historic bill includes significant improvements for API women and girls, including banning insurance companies from discriminating against women by rescinding or denying care based on preexisting conditions.² However, it continues to limit health care for immigrants and restrict abortion access. Nevertheless, NAPAWF applauds PPACA for providing new healthcare coverage for 4.5 million women in United States.³ PPACA changes the insurance infrastructure that has obstructed women’s access to better health care. As a founding platform for NAPAWF, better health care for API women and girls is an important win.⁴

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INCREASED COVERAGE

Medicaid Expansion

Expanded Medicaid access will increase health care coverage for

Asian Americans and Pacific Islanders. Approximately 3.8 million⁵, or 31% of Asians and 45% of Native Hawaiian and other Pacific Islanders, compared to 26% of Caucasians, obtain healthcare via Medicaid or are uninsured.⁶ Meanwhile, 16% of the API population over the age 64 lives below the poverty level, compared to 12% nationally.⁷

Thus, API women and girls are critical beneficiaries of the expanded coverage. Women account for over 70% of Medicaid beneficiaries and a disproportionate percentage of them are women of color.⁸ 18.2% of API women (compared to 17.7% of all women) do not have health care coverage.⁹ As a result, many API women forgo critical preventive health care: 29.2% of API women have not had a mammogram for the past two years, and 24.1% have not had a Pap Test in 3 years.¹⁰ Additionally, women of color are diagnosed for diabetes and cardiovascular diseases at a higher rate than Caucasians, with coronary disease a leading cause of death among API women, responsible for more than a quarter of all deaths.¹¹ Up to 4.5 million women will be

newly eligible for coverage through Medicaid, which will be expanded to those up to 133% of the federal poverty level (FPL), or roughly \$29,000 a year for a family of four.¹² Since women of color are often the main health care decision-makers in their homes¹³, their own lack of health insurance negatively impacts the rest of their families.

Approximately 11 million women will receive health insurance subsidies to help pay for premiums and out-of-pocket costs of exchange-based health plans. Additionally, subsidies will be available to those with family incomes up to 400% of the FPL, or roughly \$88,000 a year for a family of four.¹⁴ States have new and immediate opportunities to expand Medicaid coverage for family planning to women and men at the same income eligibility level for pregnancy health services for women, with no cost-sharing.¹⁵ To ensure that copayments and deductibles are no longer a barrier to preventive care, the law requires plans to cover and eliminate cost-sharing for all preventive services and screenings recommended by the US Preventive Services Task



Force (USPSTF). Insurers are also required to cover—with no cost-sharing—key preventive health services for women in particular, to be defined by a designated federal agency.

Prohibiting Abusive Insurance Practices

PPACA prevents private insurance companies from gender rating, an industry practice to charge women at a higher premium than men for the same health care coverage even for policies that do not include maternity care.¹⁶ Gender rating is detrimental to women. It prevents small to medium sized businesses from offering adequate health insurance, if at all, to its employees due to the high deductibles that insurance companies impose on women.¹⁷ Individual policies also often charge extra for maternity coverage or exclude it altogether.¹⁸

The PPACA will prevent insurance companies from charging women higher premiums for preexisting conditions, including pregnancy, C-section, breast or cervical cancer, or being a survivor of domestic or sexual violence.¹⁹ Women will have “direct access” to obstetrical and gynecological care without requiring prior approval.²⁰ Lastly, the PPACA will allocate new tax credits to help small businesses provide coverage to their employees, as well as access to affordable small group health coverage through the state insurance exchanges.²¹ This change directly impacts API women since they are primarily employed in small businesses or are business owners. The number of Asian women-owned businesses surged 69 percent between 1997 and 2004, twice as fast as other minority

groups.²² The health care reform would benefit employers and employees alike in obtaining insurance coverage collectively as a business or individual.

In addition, PPACA now allows parents to keep dependent children on their health care plan until age 26.²³ Young women—who are more likely than women in any other age group to be uninsured—will benefit from this change.

However, the PPACA did not ban age rating. Premiums in the small group and individual markets still vary by age—insurers can charge the oldest person as much as three times more than the youngest person in a group.²⁴ Other factors may also influence premium rates, such as tobacco use, geography, and whether the coverage is for an individual or a family.²⁵ Changes in premium rates may affect multi-generational households or family businesses. Furthermore, women’s incomes and savings are lower due to a lifetime of systematic wage discrimination, potentially leaving them in a position where they might not be able to afford health care when they retire before 65, the Medicare age limit.²⁶

Improved Data Collection

The PPACA will improve accurate data collection with three sets of provisions. First, PPACA mandates data collection on race, ethnicity, sex, primary language, and disability status by all federally funded health care and public health programs. Data will generate realistic estimates of these factors. Resulting data analyses will help monitor trends in health care disparities.²⁷ Although Medicare has obtained

race and ethnicity information about its beneficiaries from the Social Security Administration for many years, there are significant deficiencies in the accuracy and completeness of the data.²⁸ This provision is particularly useful for API communities because the improved data would highlight disparity gaps. Furthermore, disaggregated and cross-tabulated data would provide more insights to helping minority groups that have been obscured in the larger group data.

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**A STEP BACKWARD:
 ABORTION AND IMMIGRANT
 POLICY REGRESS**

Reduced Abortion Coverage

The treatment of access to abortion services during the health care reform debate was troubling. In 2009, the House of Representatives voted favorably for the “Stupak Amendment,” which prohibited health insurance plans within the newly created exchanges from offering abortion coverage, except under the narrow exceptions currently allowable under the Hyde Amendment (to preserve the woman’s life or in the case of rape or incest). Women who receive any federal subsidy at all could not use personal funds to purchase a private plan that covers abortion, except for those limited circumstances.

Although the Stupak Amendment lost support, The PPACA includes the Senate’s equivalent, the “Nelson Amendment”. This amendment sets up stringent segregation requirement to abortion coverage: a health care plan that covers abor-

tion must establish separate accounts in which to deposit the payments for abortion coverage and the payments for all other insurance coverage. Anyone who receives federal subsidies to purchase health insurance must make two separate payments—one for their insurance premiums, one for abortion coverage. These restrictions may result in insurance providers dropping abortion coverage altogether if they deemed the segregation requirements too onerous to comply with. It also increases difficulty for API women because many API women rely on Medicaid for their insurance, which does not offer abortion. A two-payment system might also deter those on private insurance to seek abortion plan inclusion because of the segregated payments requirement.

Continued Immigrant Exclusion

Under the PPACA, immigrants continue to face high barriers in obtaining public health care. Many legal immigrants are currently uninsured because they work in small business or industries that do not offer health care coverage.²⁹ While PPACA will help some businesses obtain private insurance through federal subsidies, Medicare remains out of reach since legal immigrants are only eligible after a five-year waiting period (the “5 year bar”). As many as 600,000 legal immigrants who cannot afford health care would be eligible for Medicaid if the five-year waiting period were eliminated.³⁰ This waiting period is especially harmful for women since they comprise over half of the immigrant population.³¹ Furthermore, the PPACA bars undocumented immigrants from participating in the private insurance exchanges,

which are expected to replace the current individual market over time.³² This may cause people to lose their current coverage and deny alternative insurance access.

CONCLUSION

Overall, the Patient Protection and Affordable Care Act is a bittersweet win for API women. It expands Medicaid, bans gender rating, and improves data collection for more accurate analysis on health care disparities. However, the PPACA regresses abortion policies and continues to prevent legal immigrants from obtaining public health insurance without a waiting period. The PPACA was only the beginning and advocates will continue to work toward fair health care and reproductive justice policies.

¹ National Asian Pacific American Women’s Forum, *NAPAWF Statement on the President signing Health Reform Bill*.

² *Id.*; Denise Grady, *Overhaul Will Lower the Costs of Being a Woman*, NY TIMES, Mar. 29, 2010, <http://www.nytimes.com/2010/03/30/health/30women.html>

³ National Women’s Law Center, *Women and Health Care Reform At-A-Glance 1*(2010), http://nwlc.org/reformmatters/pdf/HCR_AtAGlance_Fact%20Sheet.pdf [hereafter *At-A-Glance*].

⁴ National Asian Pacific American Women’s Forum, *NAPAWF Health Platform Paper*, <http://napawf.org/wp-content/uploads/2010/02/health.pdf>

⁵ THE HENRY J. KAISER FAMILY FOUNDATION, *THE ROLE OF HEALTH COVERAGE FOR COMMUNITIES OF COLOR* Fig.10, Nov. 2009, <http://www.kff.org/minorityhealth/8017.cfm>

⁶ *Id.*
⁷ Women of Color United for Health Reform, *Health Reform Imperatives for Women and Communities of Color*, <http://www.womenofcolorunited.net/learn-more/>

⁸ National Asian Pacific American Women’s Forum, *Health Care Coverage and API women*. <http://napawf.org/wp-content/uploads/2009/10/>

[Health-Coverage-and-API-Women-Factsheet.pdf](#); Women of Color United for Health Reform, *Health Reform Imperatives for Women and Communities of Color*, <http://www.womenofcolorunited.net/learn-more/>

⁹ THE HENRY J. KAISER FAMILY FOUNDATION, *PUTTING WOMEN’S HEALTH CARE DISPARITIES ON THE MAP: EXAMINING RACIAL AND ETHNIC DISPARITIES AT THE STATE LEVEL* Table 2.7, June 10, 2009, <http://www.kff.org/minorityhealth/upload/7886.pdf>

¹⁰ *Id.*
¹¹ Women of Color United for Health Reform, *Facts*, <http://www.womenofcolorunited.net/learn-more-facts/>

¹² *At-A-Glance*
¹³ WOC principles

¹⁴ *At-A-Glance*
¹⁵ *Id.*

¹⁶ *At-A-Glance*, NESRI factsheet

¹⁷ Times

¹⁸ Times

¹⁹ *At-A-Glance*.

²⁰ *Id.*

²¹ *Id.*

²² <http://www.azcentral.com/arizonarepublic/business/articles/0519asianwomen19.html>

²³ *At-A-Glance*.

²⁴ NWLC – Insurance reform.

²⁵ NWLC – Insurance reform

²⁶ <http://www.rhrealitycheck.org/blog/2010/03/23/updated-health-care-bill-womens-health-wins-losses-challenges>

²⁷ KFF – health reform sheet.

²⁸ Congressional Research Service, pg.77

²⁹ APIAHF.

³⁰ APIAHF.

³¹ NATIONAL latina institute <http://latinainstitute.org/news/NLIRH-commends-Congress-on-health-reform-efforts-cautions-that-the-work-is-not-done>

³² NESRI immigrants fact sheet.

information about how the reform impacts you. For more information, please visit www.healthcare.gov for more tools and helpful