

**REVIEW**

# The ramifications of recent health policy actions for cardiovascular care of women: Progress, threats, and opportunities

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Women's health and well-being are shaped by a combination of healthcare policies that impact the type of health insurance coverage they benefit from, as well as access to preventive, screening, and treatment services. Furthermore, more distal policies, such as those that pertain to housing, education, and employment, as well as social determinants of health, such as issues of socioeconomic status and women's status in society, also impact their cardiac health. Before the passage of the Affordable Care Act in 2010, women were at greater risk of facing barriers to coverage, reflecting gender rating and the higher likelihood of the existence of preexisting health conditions such as a previous pregnancy. The ACA made substantial progress in responding to women's health needs by expanding the numbers of low-income groups eligible for Medicaid (for the 32 states and Washington, DC that expanded the program) and other subsidized healthcare, as well as access to preventive health services. Although health reform efforts to eliminate the ACA failed in 2016, the administration and Congress are using a variety of channels, including the new Tax Cuts and Job Act, to implement policies such as the elimination of the individual insurance mandate, as well as the elimination of premium subsidies, that will likely impact women differentially, potentially undoing the progress that has been achieved over the past decade.

**KEYWORDS**

Health Care Reform, Proximal and Distal Policy Impact, Tax Reform, Women's Cardiac Care

## 1 | INTRODUCTION

Women's health and well-being are deeply shaped by a combination of public policies. These include proximal policies such as health insurance coverage and access to care, regardless of a patient's gender, economic profile, and where they live. These policies, in turn, shape the types of opportunities women have to receive effective primary and secondary prevention, disease management, and treatments for heart disease. Women's health is also shaped by distal policies, for example, those aimed at increasing access to smoke-free environments and heart-healthy foods that prevent a variety of health problems, including heart disease, before they become problematic and expensive to treat. Other distal factors include educational opportunities, employment training and practices, family leave policies, housing policies, and overall environment, for example, quality of air, safe communities for physical activity, and exposure to

toxins.<sup>1</sup> Increasingly, society also recognizes the insidious impact of additional factors, such as income inequality in salary structures, social immobility, racism, conscious and unconscious bias, sexual orientation discrimination, and women's social status and overall position in society, on women's health.<sup>2,3</sup>

In 2008, approximately 19 million women between the ages of 18 and 64 years old were uninsured. A Kaiser Family Foundation survey found that 56% of uninsured women did not receive needed care due to cost, whereas only 13% of women with health insurance cited cost as a barrier to receiving the care that they needed. The survey also concluded that women without insurance coverage often received a lower standard of care and had poorer health than those who had insurance.<sup>4,5</sup> Cardiovascular outcomes for low income and minority women are poorer than their white female and all male counterparts, and is likely in part due to insurance coverage.<sup>6,7</sup>

Chronic health diseases and conditions, such as heart disease, cancer, and diabetes, have been the leading cause of death for women. Nearly half of all adults—133 million people—have a chronic illness, and half of those have 2 or more chronic conditions.<sup>8</sup> Thirty-eight percent of women suffer from 1 or more chronic diseases, compared to 30% of men.<sup>9</sup> As a result, approximately 75% of all US healthcare dollars relate to the treatment of patients living with chronic conditions.<sup>10</sup> Traditionally, extensive disparities have existed in women's access to preventive services, health insurance coverage, and access to care. Furthermore, elder and long-term care issues affect women more often because they live longer, have higher rates of disability and chronic health problems, and have lower incomes than men on average. This places women at greater need for federal, state, and community resource policies such as Medicaid and Medicare coverage.<sup>11</sup>

With the passage of the 2010 Patient Protection and Affordable Care Act (ACA), a policy window provided women a pathway to improve their overall health and well-being, including many that directly impact women's cardiovascular health. As a result, the ACA extended coverage to some 21 million, mostly low-income Americans, including millions of children.<sup>12</sup> It was largely paid for by 2 tax increases on the wealthy—a 3.8% increase on their capital gains taxes and other investment-related income, and a 0.9% surcharge on their Medicare taxes. These tax increases, along with the increased government expenditures required to provide extended coverage of the US population, represent major reasons why Republicans have wanted to repeal the ACA since its inception.<sup>13</sup> Today, many of the ACA insurance mandates, coverage, and essential benefits for a variety of preventive and treatment services aimed at improving women's health are being threatened with the loss of federal subsidies, health insurance marketplace instability contributing to premium increases, and substantial reductions to women's preventive health funding.<sup>14</sup>

This article provides both a look back at what policy elements were crucial in making inroads in women's cardiac care since the implementation of the ACA, the potential effects of repealing key elements of the ACA, and the substantial threats to health coverage reflected by the proposed federal tax reform bill. Although important in shaping healthcare delivery options, quality, cost, and health outcomes issues, such as the consolidation of healthcare private practices with hospitals and the weakening of the Centers for Medicare & Medicaid Services value payment effort aimed at maintaining Medicare's fiscal solvency, are beyond the scope of this article.

## 2 | WHAT WAS BUILT INTO THE ACA FOR WOMEN TO EVEN THE PLAYING HEALTH INSURANCE FIELD?

The ACA made several fundamental changes in who was eligible for health insurance coverage, many of which directly impact women's health status. First, the ACA added provisions that allowed more people to gain coverage regardless of their health status. Thus, starting in 2014, private insurance plans no longer were able to deny coverage to women based upon a preexisting condition, which included such conditions as a previous pregnancy or a depression diagnosis.

Second, the practice of charging women higher premiums in the individual insurance market, known as gender rating, was also prohibited. Previous studies indicate that women were often charged between 10% and 50% higher premiums than men.<sup>15</sup>

Third, the ACA required all new individual and small group health plans (sold both outside and inside state and federal exchanges) to cover a range of essential health benefits. Essential health benefits include services that are especially relevant to women (Table 1). Coverage under Medicaid expansion also was required to be equivalent to essential health benefits.<sup>16</sup>

Fourth, health insurance coverage was dramatically changed for the most vulnerable populations as a result of Medicaid expansion to nonpregnant, low-income populations, implemented in 32 states and the District of Columbia, assuring a substantial change in women's access to care. This federal–state partnership allowed for the removal of the cap for federal funds for the Medicaid program.<sup>17,18</sup>

Fifth, the ACA made major changes in federal subsidies to assist individuals and their families with incomes up to 400% of the federal poverty guidelines (\$94,200 for a family of 4 in 2013) who purchase private insurance. This effort recognized the wide variability in the proportion of uninsured women ages 18–64 years across the country who would be eligible for such subsidies, for example, as high as 50% in New Hampshire and as low as 29% in New Mexico.<sup>11</sup>

Sixth, the ACA prohibited copayments or coinsurance for specified preventive services relevant to both men and women for heart health, including annual well visits, tobacco screening and cessation interventions, aspirin for heart disease prevention and blood pressure, diabetes, and lipid screening.<sup>19</sup>

**TABLE 1** Essential benefits and their relationship with cardiovascular health care

Those with Direct Cardiovascular Care Benefits	Other Essential Benefits—Many With Indirect Cardiovascular Care Benefits
Preventive and wellness services	Maternity care
Chronic disease management	Newborn care
Ambulatory patient services	Mental health/ behavioral health services <sup>a</sup>
Emergency services	Substance abuse disorder services <sup>b</sup>
Hospitalization	Oral <sup>c</sup> and vision care
Prescription drugs	
Rehabilitation services and devices	
Laboratory services	

Essential benefits under the Affordable Care Act include maternity and newborn care, preventive and wellness services, and chronic disease management. In addition, essential health benefits include: ambulatory patient services, emergency services, hospitalization, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices (eg, to help regain lost functions or to help acquire new functions), laboratory services, and pediatric services including oral and vision care.

<sup>a</sup> Treatment of depression will benefit outcomes for patients with cardiovascular disease.

<sup>b</sup> Management of opioid use disorders reduces risk of endocarditis from injection drug use.

<sup>c</sup> Oral care reduces risk of endocarditis, and may reduce cardiovascular risk from chronic inflammation from periodontal disease.

Each of these components built into the DNA of the ACA has contributed to improvements for women's health coverage. For example, between 2013 and 2015, the uninsured rate among women fell from 17% to 11% among women ages 19 to 64 years, a record low.<sup>20</sup> The availability of women accessing an annual preventive health visit, without copayments or deductibles, provided a platform for early screening and detection of high blood pressure and other health conditions relevant to cardiology. As a result, in 2016, 55 million women benefitted from this array of preventive health services without cost sharing.<sup>21</sup>

It is noteworthy that although significant progress was achieved in expanding health insurance coverage, 1 significant group was either delayed in their ability to gain coverage or was permanently marginalized from purchasing health insurance coverage—immigrants lawfully living in the United States for less than 5 years and undocumented immigrants. A recent study by the Kaiser Family Foundation on the impacts of immigration restrictions and increased immigration enforcement since the beginning of the Trump administration on individuals' health, documents that many immigrants from a variety of backgrounds report negative outcomes, specifically fear and anxiety that affects their daily lives as well as the health of their children, who are predominantly US-born citizens.<sup>22</sup>

Health and related problems impacting families include social isolation, increased limits on community and employment participation, and mental health issues for both adults and children ranging from problems sleeping through depression and anxiety, all of which may have long-term health consequences on children and their families.<sup>22</sup> Apart from health insurance coverage, several other elements were incorporated into the ACA that held promise for improving the cardiac health of women. Examples include the Prevention and Public Health Fund, which supports a range of preventive health efforts including those directly related to heart disease—the Million Hearts program, the Office of Smoking and Health, and the National Training Programs.<sup>23</sup> The training programs support workforce development and prevent local workforce shortages, spanning nursing assistant and home health aide training through primary care residency training.<sup>24</sup>

### 3 | CURRENT STATUS OF HEALTHCARE REFORMS

Although Congress' efforts to reform healthcare were unsuccessful in 2016, a variety of Trump administration policy decisions have greatly contributed to weakening the progress that has been made in meeting the myriad health needs of women. First, the administration eliminated cost-sharing subsidies that helped to lower the cost of insurance in the private marketplace, particularly for those who are not eligible for premium subsidy support. This subsidy, estimated to be \$51 billion in 2017, represented an important lifeline to health insurance coverage for millions of Americans.<sup>25</sup> The lack of subsidies is anticipated to result in health insurance market destabilization, contributing to increases in insurance premiums to offset the loss of the payments, and the potential exiting of insurance companies from the healthcare marketplace.<sup>26</sup>

Second, efforts to undermine the ACA include the elimination of funding that previously promoted open health insurance enrollment in the federal and state health insurance marketplace, beginning in November 2017. Specifically, the federal government eliminated 90% of funding for social media outreach and enrollment strategies and 40% of outreach and enrollment worker funding, which is particularly important in reaching under-represented and harder to reach populations. Additional efforts to reduce the number of new insurance enrollees necessary to expand the health insurance pool was reflected in the administrative decision to shorten the enrollment period from 90 days to 45 days and shutting down the federal marketplace website for "maintenance" on weekends, when many individuals have more opportunities to use this resource to shop for health insurance coverage.<sup>27</sup> Despite these restrictions on enrollment, the enrollment number in 2017 to date has exceeded those in the prior year, supporting the popularity of insurance coverage by the public. However, enrollment numbers will likely remain overall less than the end of the previous enrollment period. Most recently, as described below, tax reform will likely impact future healthcare coverage and access to care.

### 4 | POTENTIAL THREATS TO THE NATION'S HEALTH WITHIN THE TAX CUTS AND JOB ACT

In addition to the aforementioned efforts to substantially undermine the ACA, Congress has incorporated a repeal of the individual health insurance mandate as part of its Tax Cuts and Jobs overhaul bill, signed into law in late December 2017. At first glance, there is little specific language in the bill that appears to affect federal spending on healthcare. However, 3 major threats are apparent in the proposal—2 that can proximally impact health and 1 that is distal but also promises to shape women's cardiac care.

First, the Act incorporates the elimination of the individual mandate, which was originally incorporated into the ACA as it was central to reducing the number of uninsured Americans. The mandate helped to control healthcare costs for everyone by broadening the pool of those who had health insurance coverage and helping to ensure the wide availability of affordable health insurance coverage. With the new mandate, fewer individuals will likely apply for Medicaid coverage. This would result in an estimated \$318 billion dollars in savings, which would be redeployed to help pay for the proposed tax cuts as a way to generate federal savings to stay within the requirement to not exceed a \$1.5 trillion reduction in federal revenue.<sup>28</sup>

According to the Congressional Budget Office (CBO), there would be an anticipated 10% increase in premiums in the individual market in most years over the next decade, as well as an estimated 13 million fewer people covered by health insurance by 2027.<sup>29</sup> This would likely occur as "healthier people would be less likely to obtain insurance and because, especially in the nongroup market, the resulting increases in premiums would cause more people to not purchase insurance."<sup>29</sup>

As a result of the dramatic increase in the number of the uninsured, there will likely be an increase in the incidence of uncompensated care. The provision is also likely to reduce total reimbursement

to safety-net providers, potentially handicapping their ability to invest in delivery-system improvements, such as telehealth or team-based care, which have been shown to improve timely access to care. This roll-back in the numbers of individuals who currently have Medicaid and health insurance through state and federal exchanges is particularly challenging in light of the 28 million who remain uninsured across our country, especially in rural and southern parts of our country.<sup>30</sup>

Since the ACA and Medicaid expansion took effect, researchers<sup>31-33</sup> have been tracking the effects of expanded coverage on Americans' financial well-being. Recent findings suggest that gaining Medicaid coverage is associated with declining medical debt, fewer personal bankruptcies, improved credit scores, and reduced reliance on predatory lending practices. For example, using a nationally representative panel of 5 million credit records,<sup>33</sup> it was found that the expansion "reduced unpaid medical bills sent to collection by \$3.4 billion in its first two years, prevented new delinquencies, and improved credit scores." The study also found "approximately 50,000 fewer bankruptcies over the first two post-reform years."<sup>33</sup> This is key as credit scores can determine whether someone is approved for an apartment, mortgage, car loan, cell phone plan, or credit card, and what interest rate or security deposit they must pay. The scores are also often used to determine how much someone pays for home or auto insurance.<sup>34</sup>

A second significant policy ramification is even more threatening to women's health. The anticipated cuts in federal taxes will likely trigger a crisis by exacerbating the challenge of meeting the financial obligations for Medicare and Medicaid.<sup>28</sup> Thus, if the federal government exceeds the \$1.5 trillion deficit over the next decade, the deficit will likely destabilize financial support for federal health programs, triggering automatic cuts of \$136 billion in automatic sequester cuts from mandatory spending in 2018 for several programs, specifically Medicaid, Medicare, and the elimination of the Prevention and Public Health Fund. This is because Congressional pay-as-you-go rules, called PAYGO, require that the Office of Management and Budget automatically cut mandatory spending if legislation increases the deficit beyond a certain point.<sup>35</sup> These automatic cuts are in concert with what was originally signaled by the Republican's 2018 Senate budget resolution proposal, which called for a \$470 billion dollar reduction in Medicare spending and a \$1.3 trillion reduction in Medicaid spending over the next 10 years (representing a 25% cut to this program).<sup>28</sup> Apart from PAYGO maneuvers, the sheer size of the tax cuts will necessitate future budget decisions during which additional health programs or health funding could be cut. Given that the bill is projected to expand the deficit by \$1.5 trillion, and Speaker Ryan and others are calling for additional future entitlement reforms, the tax bill will create pressure regarding where to invest limited (and potentially declining) tax revenue.<sup>28,35</sup> The effect of the federal tax reform legislation on federal healthcare programs is comparable and potentially even more damaging than the Trump administration's actions to sabotage the ACA.<sup>28</sup>

Third, although distally influential for women is the CBO calculation that the Tax Reform and Job Act will dramatically contribute to our country's rising income divide, with the likelihood of a major impact upon the nation's health. The redeployment of public funds to private business interests, with the top 1% of income earners deriving

approximately half of the federal tax reductions, and the lack of substantial tax relief for lower and middle classes, would further increase our nation's income inequality, a key social determinant of health that contributes to poorer health outcomes.<sup>36</sup>

Thus, close monitoring of how these policy decisions impact economic and health outcomes is needed. The lack of system equity, with higher value placed on the wealthy as compared to investments that would help those with low income, the disabled, and the elderly access basic healthcare, raises a variety of ethical issues, particularly as the tax policy will cause a dismantling of a long history of over 50 years of federal health policy investments.<sup>28</sup>

## 5 | CONCLUSION

Increased awareness and advocacy by the public and providers will be required to preserve these important benefits and programs.<sup>14,37</sup> Women's health, particularly in women who are managing a chronic health condition, is deeply impacted by the ability to benefit from having stable health insurance coverage, along with high-quality healthcare coverage. As a nation, we also need to recognize the importance of primary prevention such as adoption of the new clinical guidelines pertaining to hypertension. As the country implements a number of major policies, we need to recognize those that are directly impacting healthcare coverage and access to care (proximal), as well as those distal actions that also shape the lives, health, and well-being of women and their families. The American College of Cardiology developed a series of principles for healthcare reform in February 2017 that are relevant as our country continues to debate ways to better manage healthcare resources.<sup>38</sup> These principles include preventing the loss of healthcare coverage by assuring access through public and private programs; guarantees to affordable coverage options for patients with cardiovascular disease or other preexisting medical conditions; improving access to and coverage of preventive care; expansion of the nation's investment in research, prevention, public health, and disease surveillance; maintaining a firm commitment to patient-centered, evidence-based care; and minimizing barriers to the delivery of efficient, high-quality cardiovascular care in all practice settings. These principles continue to be relevant as major policies are shaped and implemented by policymakers and are key in furthering the agenda to improve the health of women.

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## Conflicts of interest

The authors declare no potential conflicts of interest.

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