

Expanding Women’s Healthcare Access in the United States: The Patchwork “Universalism” of the Affordable Care Act

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I. Introduction

Access to health care is a vital basic need that enhances human capabilities on many levels. As with most aspects of everyday life, especially those concerning the delivery of care, women's relationship to health care provision as well as their needs differ from men's. Compared to men, women tend to have more contact with health care systems over their lifetime (in part because they live longer); have greater needs during child bearing years; and as primarily caregivers interface with health care providers on the behalf of others.

The human right to health, including the right to the highest attainable standard of physical and mental health and access to all medical services, is widely recognized. As defined by the United Nations Office of the High Commissioner of Human Rights, "The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health (United Nations Human Rights, n.d.(a))." There are several international conventions that protect the right to health. Although, article 25 of the Universal Declaration of Human Rights (UDHR) specifies the right to health, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR) codify the UDHR articles into international law for States to ratify (United Nations n.d.). The United States has ratified the ICCPR but not the ICESCR (United Nations Treaty Collection 2013). Even so, the United States has never assured health care access as a human right, most evident by the lack of universal coverage.

The World Health Organization (2013) defines the goal of universal health coverage as ensuring that "all people obtain the health services they need without suffering financial hardship when paying for them." This definition concisely identifies the three key elements of universal health coverage: that all (or nearly all) residents have access to health services, the levels of services provided are adequate, and the cost is affordable. While most affluent countries have had universal health care coverage for decades, the United States has not.¹ In 2011, 15.7 percent of the US population was uninsured (Authors' calculations 2013).² Further, prior to sweeping healthcare reform in the United States, private insurers have had broad authority to accept, reject, and set different rates for applicants, to decide which medical procedures and medications they would cover at what prices, and set life-time spending caps. So, that even those with insurance could find themselves uncovered for needed medical services.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, commonly called "Obamacare" (referred to here as the ACA). It

was a watershed event, bringing the United States closer to universal health coverage after decades of failed attempts. The provisions of the ACA are being phased in over a five year period. Once fully implemented, the ACA will extend coverage, ensure greater consumer protections, and require all plans to include basic health services. Largely based on the universal health care reform implemented in the state of Massachusetts in 2006, the ACA builds on the current complex, decentralized and market-driven system of private and public provision of health insurance and health care services. It does this by expanding the private market through mandating uninsured individuals to purchase private plans through state-level Exchanges, penalizing larger employers that do not provide employees with affordable insurance plans, and expanding the public state-administered Medicaid program to cover low-income adults. The federal government will provide tax credits and subsidies to small employers and individuals who cannot afford to purchase private insurance and exempts certain individuals and employers. The box on ACA details the key provisions. And while the ACA certainly expands access to basic health care services, especially for women, it falls short of universal coverage and in fulfilling a commitment to health care as a human right.

This paper explores the promise of the ACA with attention to the ways gender matter by tracing the development and implementation of key US social protection systems, an examination of the current health system with particular attention to women's coverage, and the potential impacts of the ACA, including how it conforms to international human rights norms for health care. The ACA promises to vastly improve the key dimensions of health coverage in the US, but it conforms with other US social policy by relying on market-based mechanism and individual states to implement key components. In doing so it embodies long-standing gender, racial and ethnic institutional biases that will result in uneven and incomplete coverage.

BOX ON KEY PROVISIONS OF THE ACA

The Patient Protection and Affordable Care Act (ACA)

The main goals of the ACA are to: 1) expand coverage 2) improve consumer protections; and 3) reduce costs while improving the healthcare delivery system.

Expanding access

Expansion of public programs. The ACA provides states with enormous financial incentives³ to expand Medicaid coverage to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 138% federal poverty line (FPL).⁴ The federal poverty level is \$19,530 for a family of three in 2013.⁵ Medicaid is the US government program that pays for health care services for low-and moderate-income children and very low-income adults. States that expand coverage must provide the essential health benefits required in the Exchanges with one exception, most abortions are prohibited. For key elements of the current Medicaid/CHIP program see Box on US Government Programs.

The ACA also expands Medicare coverage to key preventive services with no additional charge, reduces and eventually eliminates the coverage gap (the “donut hole”⁶) for

prescription drugs, and promotes initiatives that improve care through coordinating all levels of care. Medicare is the US government program that provides health insurance coverage for persons over age 65 and those with some disabilities. See Box on US Government Programs for key elements of Medicare.

Individual mandate. Most US citizens and legal permanent residents must have health insurance by 2014 or face a tax penalty. Insurance coverage can purchase through state-based American Health Benefit Exchanges (referred to here as Exchanges). These are entities that organize the competitive market for health insurance in each state)⁷ To help promote affordability, the federal government will provide tax credits for the cost of the premium are available for those with incomes between 100 and 400 percent of the federal poverty level. Cost-sharing subsidies for deductibles, copayments and coinsurance are also available to eligible individuals/families, typically those with income between 100 and 250 percent of the federal poverty level. Individuals exempted from the individual mandate include those with religious objections, Native Americans, those without coverage for less than three months, undocumented migrants, incarcerated individuals, and financial hardship.

Employer requirements. Large employers with more than 200 employees must offer all employees health insurance coverage. Firms with more than 50 full-time-equivalent employees that do not offer any coverage but have at least one full-time employee purchasing their own insurance and receiving a premium tax credit will have to pay a shared responsibility fee. Firms with fewer than 50 full-time-equivalent employees, accounting for 76.6 percent of all establishments and 28.1 percent of all employees in 2010 are exempt from any employer responsibility requirements. Small businesses (up to 100 employees) can purchase coverage through state-based Small Business Health Options Program Exchanges. States can opt to allow businesses with more than 100 employees to purchase coverage in these exchanges.

Consumer Protections, Insurance Market Reforms

Prior to the ACA there were no standard or comprehensive sets of services, especially preventive health services, that all insurance policies had to provide, except for Medicaid. The gender rating in the individual and group insurance markets often led to lack of coverage for services that are specific to women like maternity care. Depending on type of insurance, reproductive health services like birth control pills or other methods required copayments. The ACA mandates that all qualified health plans (including through Exchanges and individual and small group markets not in Exchanges) must: cover adult children up to the age of 26 on parent's policies; provide a comprehensive set of services (which now includes maternity, newborn care, pediatric, behavioral health treatment, and prescription drugs); cover certain preventative care at no additional cost to enrollees; and provide standardized summaries of benefits and coverage for consumer transparency.⁸ The legislation prohibits insurers from charging higher premiums due to gender or health status (including pre-existing conditions) or imposing a lifetime or annual limit on essential health services and places various limits on waiting periods and deductibles.

Reducing cost, improving delivery of care

The multi-leveled, decentralized delivery system of healthcare to Americans makes administration complex and expensive. The ACA moves to simplify the process by establishing standards and rules for financial and administrative procedures that are intended to reduce costs. The law makes various changes to improve delivery of care while reducing costs in the Medicare program accomplished through modernizing financing systems, reforming provider payments, and promoting accountable care practices that prevent medical relapses.⁹

The ACA provides funding for workforce development programs to ensure a diverse cadre of health professionals and require enhanced collection and reporting of data on race, ethnicity, sex, primary language, and disability status, and require the Secretary to analyze the data to monitor trends in disparities. There will be additional monies for cultural competency investments in healthcare systems, as well as for community health centers and school-based health clinics.

Sources: HHS.gov/HealthCare (n.d.); Kaiser Family Foundation (2012a, 2012c, 2013a and 2013b); National Partnership for Women and Families (2012); and US Small Business Administration (2013).

II. Social protections in the US: The gendered welfare state and labor market regimes

The expansion of services, consumer protections, and changes to delivery system included in the ACA will improve health care coverage for women in the United States. We discuss the specific ways in Section IV. However, the original design of the ACA (as well as the subsequent challenges to it) all but assures it will not reach the goal of universal coverage. This is largely because of the vagaries of the social protection system in the United States, to which the ACA conforms. In this case, it is ACA's heavy reliance on market-based provision as well as the degree to which states have authority over the administration and policy decisions for the health care Exchanges and the expansion of Medicaid. As a result the pre-ACA differences in the types of services covered (beyond the essential one mandated by the ACA) as well as the amount of patient-costs for those same services will remain. Importantly, a substantial percentage of women (and men) will likely remain uninsured. Deep political divisions in the US Congress also led to assuring that a key women's reproductive health service (abortion) will not be covered for the women who can least afford them.

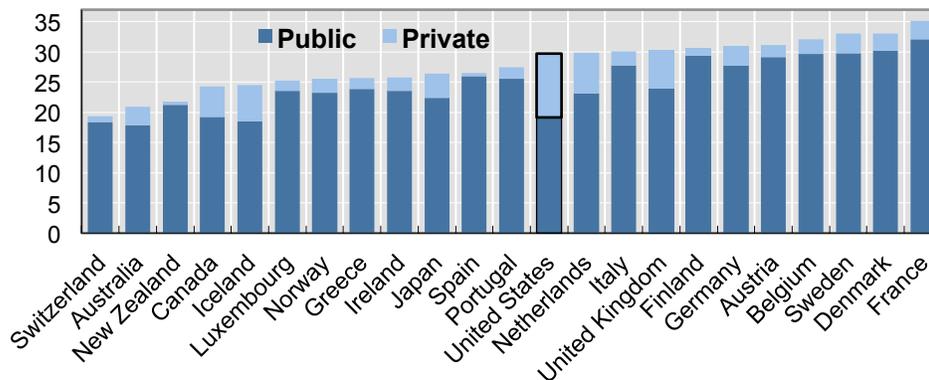
This brief overview of US welfare state and labor market regimes provides a framework for understanding the key elements in the ACA and how they will impact women.

Welfare state policies

Compared to other affluent countries, the US nation-state plays a smaller role in cushioning workers from loss of income due to old age, disability, unemployment, and

family responsibilities and in helping families pay for care of young children.¹⁰ Instead, the United States leaves individual families to rely on their own resources, especially unpaid family time and earnings. For example, while US total social expenditures as a percent of GDP are comparable to many other rich countries, the composition differs with much higher levels of private market expenditures (see Figure 1 for comparisons of public and private social expenditures).

Figure 1: Public and private social expenditure in percentage of GDP in 2009



Source: OECD 2013.

Includes spending on Old age, Survivors, Incapacity-related benefits, Health, Family, Active labor market programs, Unemployment, Housing, and Other social policy.

The United States also lags in employment and government policies that support paid and unpaid care work, with 2007 US public contribution of 1.18 percent of GDP on child payments and allowances, parental leave benefits, and childcare support compared to the OECD average of 2.19 (OECD 2011b, Figure 1.11).¹¹

The United States has a three tiered social protection system (Albelda 2011). The first tier includes government mandated employment-based programs, with the key programs of Unemployment Insurance, Old Age, Survivor’s and Disability Insurance (commonly called Social Security), and Medicare (the health care insurance program for older persons). These social insurance programs are primarily financed through payroll taxes, with eligibility linked to employment. The second tier consists of voluntary employer-provided protections with key provisions including contributions to health insurance coverage and retirement plans as well as paid time off for vacations, own illness, or parental/maternity leave. The third social protection tier includes “safety net” (anti-poverty) programs, mostly financed with general revenues, and includes programs that provide food, housing, medical, and child care assistance as well as income support (including refundable tax credits) for poor individuals or families. These means-tested programs developed separately over time and are housed in an array of government agencies with differing eligibility criteria (Albelda 2011). In general, means-tested programs are less generous than government employment-based programs, quite often stigmatized, and often do not reach eligible families (Albelda and Boushey 2007).

There is an additional complicating aspect of US social protection policies. It is the array of government levels involved in establishing rules, administration, and financing. Social

Security, Medicare, Supplement Security Income (cash assistance for poor disabled persons), the refundable Earned Income Tax Credit (EITC) for low-income earners, and the major food assistance programs are federal programs (although some are administered at the state level), with uniform benefits and eligibility criteria across the states.¹² The rest of the programs involve at least two levels of government in financing, policy and rule making, and administration. For example, cash assistance for families with children (Temporary Assistance for Needy Families) and Medicaid, the health insurance programs for poor and low-income children and some adults, are jointly financed by state and federal governments, administered by states (and in some cases local governments) with federal minimum requirements that give states a great deal of leeway on benefit levels and eligibility requirements. Between voluntary employment protection and decentralization of many government-based programs, there is enormous diversity in the type and amount of provision of social protections, especially for low-income people and families, across employers and states.

Historically, race and gender have been a very important factor in shaping social protection programs. Mandatory and voluntary employment-based benefits were initially structured to support white married male breadwinners (and through them their wives), while means-tested programs were tailored for unmarried mothers (e.g. Orloff 1993; Albelda 2011). The various tiers of protection also carry very different notions of deservedness and help serve to reproduce unequal gender relations (e.g. Fraser and Gordon 1994). Exclusionary measures have been exercised through decisions about what type of employment is covered as well as which level of government provides, funds, and defines eligibility rules. Until the 1960s, most occupations held by black and Latino workers were not covered by Social Security. Married women received coverage through husbands. Means-tested programs, that disproportionately serve people of color and/or single mothers, are also the set of social protections most likely to be provide states with considerable discretion (Mettler 1998). They determine benefit levels, eligibility levels, where to locate administrative offices, and the levels of discretion exerted by individual case workers. This discretion provides states the ability to shape their programs' generosity, ease of applying and receiving the support, and degree to which all clients are treated equally. Racial exclusion was the explicit reason why states were given so much authority over the cash assistance program for poor mothers with children in 1935 (Gordon 1994).¹³ State discretion has resulted in a higher likelihood that non-white populations will be precluded from those programs (e.g. Quadagno 1994; Mink 1998; Ward 2005; and Schram et al. 2010). Civil rights and feminist struggles have reduced many of the formal mechanisms of exclusion, but gender, race and ethnicity still remain important signifiers and dividing points in contemporary debates on social protection policies in the United States, including the ACA.

Labor market mechanisms

For most families, employment is the most important source of income for social provisioning and access to social protections. This is especially relevant in the US given the high reliance on private sources for social protection expenditures. Compared to other affluent countries, the United States places a heavy reliance on competitive labor and product markets and has lower union density and weaker collective bargaining structures

(e.g. Hall and Soskice 2001). This system of uncoordinated and competitive markets rests on social protection policies that place most of the risk of unemployment (or being in a non-earnings situation) on individuals rather than firms. Some forms this takes include minimal labor market regulation including voluntary employer provisions of paid time off and health insurance.

Access to employment and the nature of jobs also have been shaped by race, gender and ethnicity (age and citizenship status matter as well). Jobs, like social protection programs, are also segmented. Historically, women and non-whites were formally and informally excluded from most jobs that pay family wages and provide opportunities for advancement. These were also the jobs that tended to have employment-based benefits and protections (e.g. Gordon, Edwards and Reich 1982; Kessler-Harris 2007). The legacy of black slavery and servitude in the United States have helped shape the norms for non-white workers in the US, evident by the ways in which people of color, especially women, are highly over-represented in low-wage service work in the United States (Glenn 1992). The civil rights and women's movements helped to expose exclusionary practices which helped create equal opportunity policies. These have been effective for white women with college degrees, in particular. Still, gendered care norms shape women's employment choices and wages, with mothers working fewer hours than other women as well as facing a mothers' wage penalty (e.g. Budig and England 2001). While there has been some racial economic progress, high levels of racial economic inequality as measured in unemployment rates, wages, family income, and wealth still persist.

Combined, US social protection policies and labor market mechanism create mixed conditions for promoting gender equality. The segmented employment regime reinforces the tiered social welfare policy regime that together lead to high levels of income inequality among women and especially high levels of child and single-mother poverty (Albelda 2013). Women in low-wage jobs with low family income face very different sets of education and employment opportunities, wage levels, and relationship to social protections than women in higher paying jobs and high family income. In particular, low-wage jobs carry few employer-based benefits. Privatized child and elder care costs reinforce inter-class inequality. High-income women turn to low-wage women workers to help care for their children or aging parents, clean their houses, and prepare meals. At the same time, these low-wage and low-income women cannot afford quality care for their children or the same sets of time-substituting services, resulting in a range of strategies that reduce investment in children and reproduce inter-class gender inequality. Care work, much of it done informally and most often by immigrant women, pays less and has even fewer social protections than other work.

In sum, both the labor market and the social protection system in the US have developed in decentralized ways with a strong reliance on market mechanisms and state-level authority in ways that privilege certain workers, with access to jobs and these protections built upon racial and gender hierarchies. Many formal barriers have been removed, but the institutional structures that reinforce gender and racial hierarchies persist, especially in labor markets and in fragmented and decentralized means-tested programs.

III. Specific context of health care coverage and access in the US: The three-tiered US health care system

Brief history

Prior to the mid-1960s, the United States relied almost entirely on a system of privately provided health care and health insurance, led by voluntary employer-supported health insurance coverage (using group coverage). This system developed as a wage package bargaining tool for employers as well as unions (Blumenthal 2006; Brown 1999). The lower costs associated with risk sharing in group policies and very favorable tax treatment of employment-based health insurance help account for its continued usage. Under this system, women and children were typically covered in family policies through employed breadwinners. Those without employment-sponsored insurance could purchase individual plans privately. The last resort was charity care, provided through local hospitals and doctor's offices. This system left large segments of the population with all adult family members regularly detached from the labor force also regularly uncovered, including many retirees, disabled workers, and single mother families.

Legislative efforts to create national health insurance are not new, starting in the early 1900s. After attempts for large-scale reforms failed in the 1950s, supporters of universal coverage moved to a more incremental approach by promoting universal health insurance for the elderly only, building on the popularity of Social Security (Oberlander 2003) and also avoiding opposition from organized labor that favored a system of collective bargaining for health insurance with employers (Quadagno and Street 2005). These incremental attempts finally succeeded in 1965 (once a more liberal Congress was elected in 1964) with passage of the Medicare program. This program provides universal medical insurance coverage for older Americans and some younger workers with disabilities administered through private insurers, administered at the federal level. At the same time, the Medicaid program was established as a needs-based program. Medicaid was established as a joint federal and state medical insurance program made available to some categories of very poor people, including children (mostly in single mother families) and those with disabilities (Moore and Smith 2005/06). In 1997, coverage for children was greatly expanded through the State Children's Health Insurance Program (known as CHIP), an extension of the joint federal and state-level Medicaid program. The Box on US Government Programs provides more information on how these programs work.

This historical progression of health insurance coverage forms the basis for the three key mechanisms in which US individuals and families have received health insurance coverage. They are thoroughly consistent with the sets of social protections discussed in the previous section. Coverage comes through government means-tested programs for poor children (and sometimes their parents) and disabled adults, mandatory employment-based coverage for seniors, employment-based voluntary programs, and the private individual coverage for everyone else. Each of these rely on the private insurance market to provide group and individual plans. This health insurance system has created a very uneven system of health care coverage and delivery, with substantial portions of the population uncovered, relying on charity care or paying out-of-pocket. Medical pricing

of services and equipment, outside of Medicare and Medicaid, is largely unregulated, resulting in both high prices and widely varying prices for the same procedures under group or non-group private insurance (Rosenthal 2013). In 2011, 15.7 percent of the US population had no health care insurance coverage (Authors' calculations). Further, until the ACA, private insurers had broad authority to accept, reject, and set different rates for applicants as well as to decide which medical procedures and medications they would cover and set life-time spending caps, leaving even those with insurance uncovered for needed medical services. Over the last several decades, escalating health care costs, due in large part to increased uses of technology and increased prevalence of chronic diseases, outpaced increases in income and government revenues (e.g. Social Security Advisory Board 2009, Ginsburg 2008).¹⁴ These higher costs placed a larger fiscal burden on federal and state governments and increased the cost of health insurance policies. Each of these pressures conspired to make health care reform a key legislative priority by the mid-2000s.

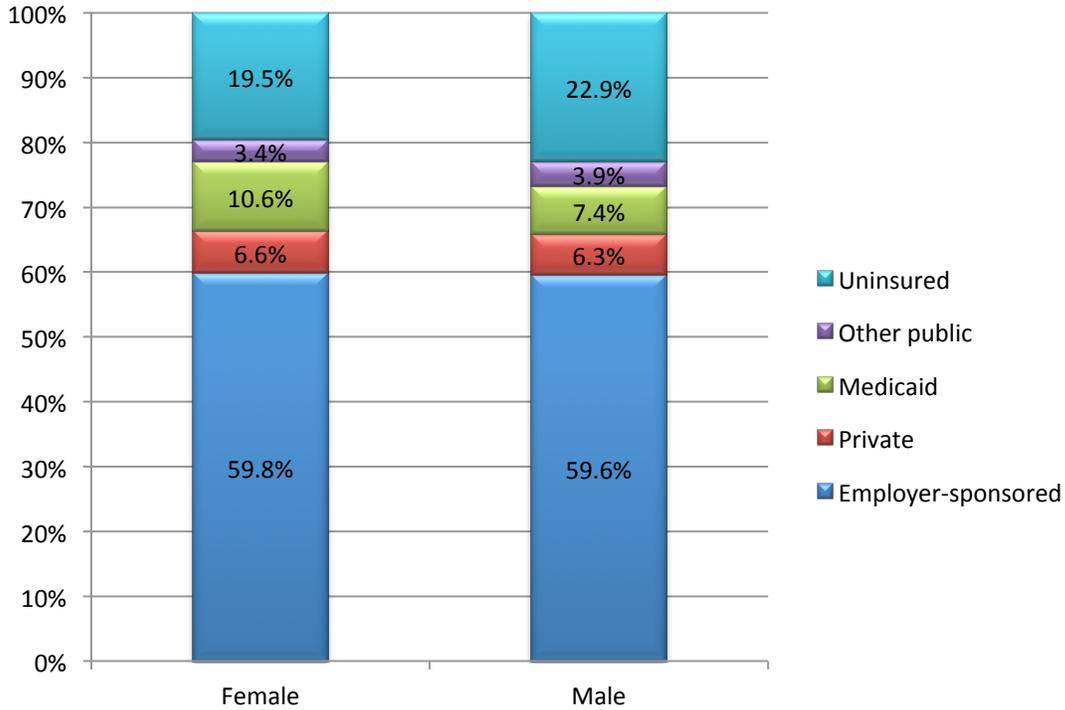
*Unequal health care coverage*¹⁵

Relying on the three-tiered system leaves a substantial coverage gap for men and women. People without health care insurance are far less likely to get the care they need. Uninsured women are much less likely than those with insurance to: visit a provider; have a regular provider; get access to specialty care; or receive preventative care (Kaiser Family Foundation 2011). Further, those that are insured report that affordability is a problem. One-quarter of women report going without or delaying needed care and filling prescription due to costs, especially for low-income and uninsured women (Kaiser Family Foundation 2011).

Almost all women and men 65 years and older (98.3 percent and 98.2 percent respectively) and most children under age 18 (90.6 percent) are covered through government-sponsored or employment-based insurance. Of the adult populations ages 18-64, the population most likely to be employed but least likely to be eligible for government-supported coverage, 21.2 percent had no health insurance coverage in 2011. Over half of those (55.0 percent) were employed with a median family income of \$29,200, compared to the 67 percent employed with a median family income of \$65,000 among those that had insurance. Here we primarily focus on women 18-64 years of age. Of the 98.3 million women in this age group, 19.2 million were uninsured (19.5 percent) compared to 22.9 percent (21.7 million) of men the same ages. Figure 2 depicts insurance coverage by type for women and men ages 18-64 in 2011.¹⁶ There are only small percentage differences in men's and women's employment-based, private insurance and non-Medicaid government insurance coverage. The health insurance gender gap is almost entirely explained by their differences in Medicaid coverage. And while the percent of men and women having employer-based coverage is almost identical, women are twice as likely as men to be insured through their spouse (17 percent of men that get employer based insurance versus 35 percent of women). The disparities among means-tested government coverage and the reliance on a family member's employment-based coverage are completely consistent with the US social insurance policy construction discussed in Section II. Wives are most likely to be covered through husbands'

employment while poor single mothers are among these adults most likely to qualify and receive means-tested benefits.

Figure 2: Health care insurance coverage for women and men ages 18-64, 2011



Source: Authors' calculation using 2012 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

Because social protection policies and labor market mechanisms are shaped not only by gender, but by family structure (including marital status and presence of children), race/ethnicity, citizen status, and age, we expect to see variation in lack of health insurance coverage across these groups. Table 1 depicts the percent and number uninsured and the distribution of the entire and uninsured population of those 18-64 years by gender and family status. Table 2 includes percent and number uninsured and distribution of the entire and uninsured population of women ages 18-64 by race/ethnicity, citizenship status, age group, and family income relative to the federal poverty line (FPL) using relevant ACA-eligible categories in 2011.

Marital status is a strong predictor of who will be uninsured. Single adults, with and without children, are almost twice as likely to be uninsured than their married counterparts. Among women, single mothers have the highest percentage that are uninsured at 27.4 percent, followed by 23.9 percent of single women with no children under the age of 18. As expected, white women are much more likely to have insurance than are other women, as are those born in the US, and older women. Women who are

not US citizens face the highest level of being uninsured of any group of women explored here, followed by poor women with incomes below 138 percent of the FPL (the Medicaid expansion income level threshold).

	Percent uninsured	Number uninsured (in 1000's)	Percent of total	Percent of uninsured
Family status				
Single female, with children under 18	27.4%	3,042	5.7%	7.4%
Single male, with children under 18	31.8%	866	1.4%	2.1%
Married female, with children under 18	16.2%	4,222	13.5%	10.3%
Married male, with children under 18	16.1%	4,082	13.1%	10.0%
Single female, no children	23.9%	8,655	18.7%	21.1%
Single male, no children	31.2%	13,707	22.8%	33.5%
Married female, no children	13.2%	3,291	12.9%	8.0%
Married male, no children	13.5%	3,094	11.9%	7.6%
<i>Total</i>	<i>21.2%</i>	<i>40,959</i>	<i>100.0%</i>	<i>100.0%</i>

Source: Authors' analysis of the 2012 ASEC Supplement to the Current Population Survey.

	Percent uninsured	Number uninsured (in 1000's)	Percent of total	Percent of uninsured
Race/Ethnicity				
White	14.2%	8,804	63.2%	45.8%
Black	22.9%	3,008	13.4%	15.7%
Hispanic	37.4%	5,797	15.8%	30.2%
Asian	20.3%	1,253	6.3%	6.5%
Other	26.3%	348	1.3%	1.8%
Nativity and citizenship status				
Born in the US	16.5%	13,425	82.7%	69.9%
Foreign born, citizen	21.6%	1,720	8.1%	9.0%
Foreign born, not a citizen	45.0%	4,065	9.2%	21.2%
Age group				
18-24	23.5%	3,518	15.2%	18.3%
25-34	24.4%	5,069	21.1%	26.4%
35-44	19.2%	3,896	20.6%	20.3%
45-54	16.8%	3,764	22.9%	19.6%
55-65	15.0%	2,963	20.2%	15.4%
Family income				
Below 138% FPL	38.8%	9,108	23.9%	47.4%
139%-399% FPL	20.5%	7,856	39.0%	40.9%
400% FPL	6.2%	2,245	37.1%	11.7%
<i>Total</i>	<i>19.5%</i>	<i>19,210</i>	<i>100.0%</i>	<i>100.0%</i>

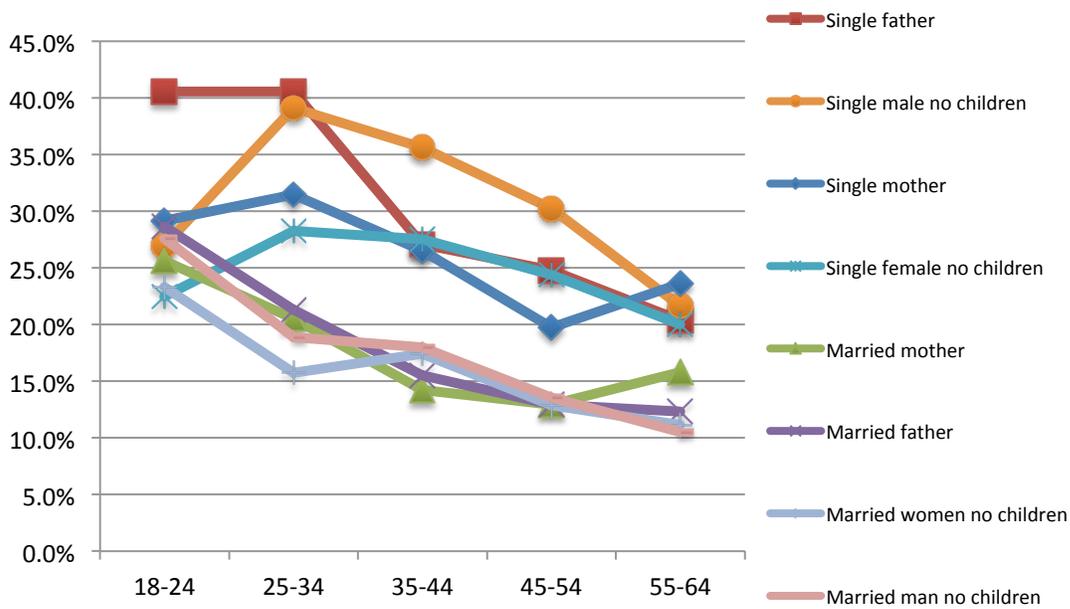
Source: Authors' analysis of the 2012 ASEC Supplement to the Current Population Survey.

There are several reasons for the variations in insurance coverage among women (and men), especially by family status. For example, married men and women with children are typically older than all other family types that may help explain why their un-insurance rates are low. Conversely, single parents and single men are much less likely to have a college degree than men and women in other family types. Single fathers and married fathers are the most likely adults to have an employer (versus being self-employed or not employed), married women (with and without children) and childless single men and women are the least, with married men without children and single mothers in between. Having an employer increases the likelihood of having employment-based insurance. Single mothers' median family income is the lowest, followed by single fathers, single women and single men.

Regression analysis helps sort out these confounding factors. Using a probability regression for adults ages 18 through 64 reveals that being poorer, younger, self-employed, not employed, a non-citizen, non-white, and having less education all significantly increase the likelihood of being uninsured. Adjusting for family income, age, education level, race/ethnicity, class of employment, age (and age squared), and citizenship status, single mothers were significantly more likely to be uninsured than married men and women (with and without children) but less likely than single fathers and single men and women. Among the likelihood of having employment-based insurance, single mothers were significantly less likely of all family statuses to have this type of insurance, adjusting for the other factors (listed above) that influence insurance coverage.

Figure 3 depicts the percent of adults that are uninsured by family status and age group for all adults ages 18-64. As adults get older, they are more likely to be insured. Still, single men and women (with or without children) are considerably more likely to be uninsured than are married women and men at all age groups, whose levels are the highest for the age group 25-34. Further, as earnings increase they are less likely to be uninsured, although married adults are less likely to be uninsured than single adults at every earnings level.

Figure 3 Percent uninsured by age group and family status, 2011

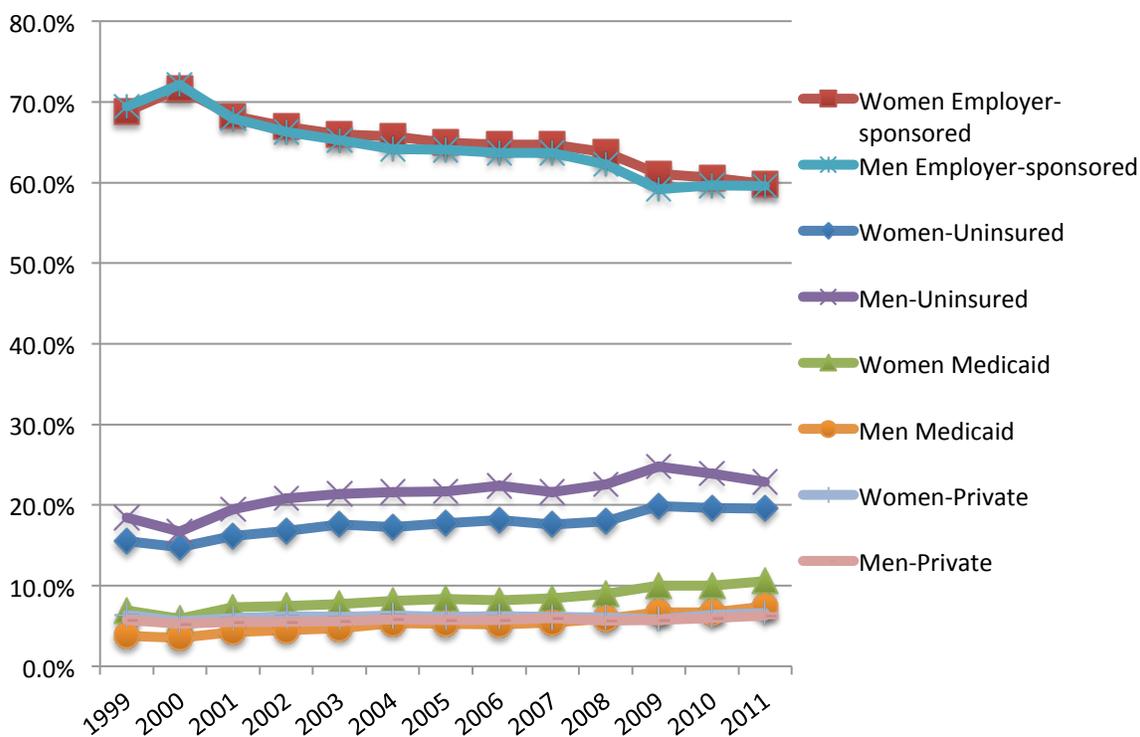


Source: Authors' calculation using 2012 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

Because the methods used to collect data on health insurance status substantially changed in the late 1980s and again in the mid 1990 and late 1990s, it is not possible to show long-term trends in coverage. Instead, we present data from 1999 to 2011 for men and women ages 18-65 in Figure 4. Employer-sponsored insurance and private coverage for men and women are almost identical over this period. Since 2000, the percentage of working age adults with employer-sponsored coverage has fallen by about 11 percentage points. Men's coverage rate dips slightly below that of women during the most recent recession, but by 2011 are almost identical. Private insurance coverage has risen only slightly (about 1 percentage point) over the same period. Government coverage (including Medicare, Medicaid and federally-sponsored veteran's health insurance) for women is higher than that of men, accounting for most of the difference in gender un-insurance gap over the entire period.

And while women are just as likely to have employer-sponsored health insurance as are men, women are much more likely to have that through their spouse. In 2011, 35.6 percent of women ages 18-64 were covered by their own employment-based health insurance compared to 44.6 percent of men.

Figure 4
Percent of men and women ages 18-64 by insurance status,
1999-2011



Source: Authors' calculation using 2012 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

Note: Percentage for Medicaid do not include individuals with multiple insurance coverage.

Prior to the ACA, insurance companies were allowed to consider gender in setting premium rates in the private individual insurance market. By 2009, among the best-selling plans in the individual market, 95% practiced gender rating (National Women's Law Center 2009). This had several gender implications. Women could be charged different (and often higher) premiums for identical health coverage as same-aged men. Policies excluded coverage for services that only women need, like maternity care. In 2009, only 13 percent of health plans provided maternity coverage to 30 year old women. Insurance policies could reject applicants for reasons that include status as a survivor of domestic violence, being pregnant, or having had a caesarean section (National Women's Law Center 2009). In short, as many pundits argued, gender was viewed by the health insurance industry as a pre-existing condition. Maternity coverage remained largely unavailable in the individual market, with few plans covering the service. Group insurance markets were also using gender-based practices with insurance companies determining premiums based on the number of women a business employed, placing women at risk for higher costs in predominately female workforces.

BOX ON US GOVERNMENT HEALTH CARE PROGRAMS

Medicaid/CHIP (before ACA expansion)

Medicaid, a means-tested program that includes the State Children Health Insurance Program (CHIP), provides health coverage to low-income children, parents, other caretaker relatives, pregnant women, seniors, and disabled adults. As an entitlement program, anyone that meets the eligibility requirements is entitled to receive the services. CHIP provides health coverage to children (up to 19 years old) in families with low incomes, but above levels that make them eligible for Medicaid. In 2011, Medicaid provided health coverage for 46.9 million people, 15.2 percent of the population.

Financing: The federal and state governments fund Medicaid/CHIP jointly, typically using general revenues. The federal government pays a percentage of program expenditures which varies by state, ranging from 50 percent in wealthier states up to about 75 percent in poorer states, with an average of 57 percent. As an entitlement, funding levels fluctuate from year to year, with increased usage during recessions. In 2011, total federal and state Medicaid spending was \$420 billion, representing 2.3 percent of GDP. States have the option to charge premiums and to establish cost-sharing mechanisms such as copayments, coinsurance, deductibles, and other similar charges. However certain groups, like pregnant women and children, are exempt from most out-of-pocket costs and copayments. As an incentive for states to expand their coverage programs for children, Congress created an enhanced federal matching rate for CHIP that is generally about 15 percentage points higher than the Medicaid rate, averaging 71 percent nationally.

Service Coverage: States administer Medicaid/CHIP programs. The federal government sets broad guidelines, including mandatory benefits, with states determining the scope of services and delivery systems within federal guidelines. States can opt to provide certain additional benefits through Medicaid programs and receive federal matching funds. Medicaid services are provided by hospitals, doctors, nursing homes and other health care providers. States can opt to provide services not covered by the federal government (like some abortions), but at their own cost.

Eligibility: Medicaid requires states to cover certain populations that include children under age 6 and pregnant women with income below 133 percent of the FPL; most seniors and disabled people who already receive cash benefits from the federal Supplemental Security Income program; and children ages 6-18 with family income below the FPL. States must also cover parents with income at or below the eligibility level set by the state prior to 1996 for its cash assistance program, but because these eligibility levels are so low and vary considerably, there is enormous variation across states but often at very low levels of eligibility. Over half the states have income eligibility for jobless parents at or below 50 percent of the FPL. Prior to the ACA there was no requirement to cover non-elder adults without children, although some states did. CHIP requires states to cover children in families with income below 200 percent of the FPL line with the option of receiving federal funding for covering children up to 300 percent. Legal immigrants are precluded from Medicaid eligibility for the first five years

they are in the United States. Undocumented immigrants are ineligible for federally funded nonemergency Medicaid and CHIP.

Women and Medicaid: Women are much more likely to be covered by Medicaid than are men, in part because they live longer than men, are dependent caretakers, and are eligible when pregnant. In 2012, 12.0 percent of women 18 and older were covered by Medicaid compared to 8.8 percent of men (Authors' calculations). Not surprisingly, women using Medicaid are more likely to be poorer, non-white, and have fair or poor health than other women. Several states (31 states) have opted to expanded Medicaid eligibility to cover the costs of family planning services (sometimes including abortion) for low-income women, and all states have established Medicaid programs to pay for breast and cervical cancer treatment for certain low-income uninsured women. Since the mid-1970s, states have been precluded from using federal Medicaid money on abortions, except in cases of rape, incest, or when the woman's life is in danger. Seventeen states provide their own Medicaid funds to finance "medically necessary" abortions. Because Medicare does not pay for non-medical care for elders but Medicaid will in certain settings, and women tend to live longer than men, there are more women over the age of 65 receiving Medicaid coverage than men (13.6 percent of women versus 10.3 percent of men).

Medicare

Medicare is an entitlement program for people ages 65 and over, people younger than 65 years old with certain disabilities, and anyone with end-stage renal disease. In 2011, Medicare covered 50.8 million people, or 16.6 percent of the population. Medicare has four parts: Part A is hospital insurance, Part B is medical insurance that includes a deductible and cost-sharing (usually 20 percent), Part C called Medicare Advantage, are for beneficiaries of Parts A and B that opt to use managed care plans. Part D is prescription drug coverage. Because Medicare has deductibles, no spending caps, and requires beneficiaries to share costs, many beneficiaries also rely on a supplemental policy through a former employer, a supplemental policy through a private insurer, or Medicaid (if eligible). As a result, health care spending in Medicare households can be high, comprised 15 percent of total household spending.

Financing: Part A is funded almost entirely through payroll taxes. Part B is optional and funded through federal general revenues and enrollee premium payments. Part C is not funded separately. Part D funding comes through general revenues and enrollee premiums. Total expenditures in 2011 were \$554 billion, 3.6 percent of US GDP.

Service Coverage: The federal government administers the Medicare programs. Part A is hospital insurance which helps cover most inpatient care in a hospital and for certain care in a skilled nursing facility, certain home healthcare services, and hospice care. Part B helps pay for certain medically necessary medical services (including physician visits and medical equipment and supplies) and some preventative services that Part A does not cover. Part D is prescription drug coverage and helps pay for some medicines, although a coverage gaps exists ("donut hole").

Eligibility: Most people 65 and over who are citizens or permanent residents are eligible for free Medicare Part A if they have worked 40 quarters and paid payroll taxes. Those ineligible for can receive it by paying a monthly premium.

Women and Medicare: Women are more likely to be covered by Medicare than are men, in part because they live longer than men. Also, a higher percentage of women than men have several chronic conditions, need help with activities of everyday living, and have cognitive or mental impairments. Because of their lower income, women with Medicare are more likely to be “dually eligible” for Medicaid – meaning they qualify for and receive both – which helps pay for long-term care services in nursing facilities. Women were 56 percent of those receiving Medicare and 62 percent of those using both Medicare and Medicaid in 2010.

Sources: Center for Budget and Policy Priorities (2013); Centers for Medicare and Medicaid (2013, Tables 1 & 19); Kaiser Family Foundation (2012b and 2013e); Medicaid.gov (2013a and 2013b); Medicare.gov (2013a and 2013b); and National Women’s Law Center (2012).

IV. Women and the ACA: Patchwork promise

Although far from the single payer national healthcare systems emblematic of OCED counterparts, the ACA makes important changes to the US healthcare system that moves the United States closer to universal coverage, consistent with the three key legislative goals of expanding access, increasing consumer protections, and reducing costs while increasing quality. Many of the provisions will have direct beneficial effect on women. The most important ones include the following.

- Increased access to affordable health insurance through Medicaid/CHIP expansion and private insurance through Exchanges.
- Mandatory insurance coverage of reproductive and family planning services (including birth control) as well as preventative medical services such as mammograms and cervical cancer screenings with no deductible or co-pay.
- Regulation of discriminatory pricing based on gender and health status, so women will be charged the same as men and cannot be denied coverage for pre-existing conditions.
- Pregnant and parent women on Medicaid and all women on Medicare will receive better coordinated and comprehensive care.
- Possible indirect benefits from better healthcare delivery systems as primary unpaid care providers as well as paid care providers through investments in workforce development for diverse populations (National Partnership for Women and Families 2012).

However, because the ACA largely extends rather than transforms the current system, it will reproduce many of the same problems of uneven costs and coverage that already exist in the complicated and uncoordinated system. Importantly, the two main avenues for extending coverage — expansion of Medicaid with substantial state-level authority and the marketplace (through employer-based access and private insurance markets) —

have historically served to disadvantage women, especially unmarried, poor, and non-white women and promise to continue doing so. Employer-base insurance coverage allows firms to make decisions about the type of coverage to provide workers, including if they will make family coverage available. As a result there will remain a great deal of variability in the plans employers offer and how much of the premium they pay. Higher paid workers not only are more likely to have insurance through their employers, they are likely to have better coverage. Workers in firms that employ large percentages of low-wage workers, on average also pay a higher percentage of their premium than other workers. They also have higher average deductibles and their employers are the least likely to provide retiree health benefits (Kaiser Family Foundation 2013f). While the ACA mandates certain services are covered, the variability that exists across employment-based coverage will persist and the degree to which women, especially women of color and immigrant women earn lower wages because they are concentrated in low wage industries (such as retail, food preparation, and hospitality), those inequality will persist among those with employment-based insurance. Similarly, as discussed earlier, when states are provided with substantial control over insurance coverage, there is considerable variability in eligibility and benefits provided, with states with higher percentage of women of color restricting eligibility and offering fewer benefits.

Further legislative mandates that preclude any federal funding for abortion (including those receiving subsidies or tax credits through the Exchanges) as well as excluding undocumented women and children (and men) from purchasing insurance coverage through exchanges will adversely impact some of the most vulnerable women and fall short of the promise of universal coverage.

Expanding Access

The state of Massachusetts implemented a similar version of the ACA in 2006. Recent data reveal that in 2011, 97 percent of the population had health insurance coverage up from 90 percent in 2006 (Commonwealth of Massachusetts 2013). These are promising results. Notably, the state paid for expanding coverage to low income adults, something not assured currently by the ACA.

Government Program Expansions. The Medicaid expansion provisions of the ACA hold significant promise for expanding coverage to uninsured women (and men) in the United States. Of the 19.2 million uninsured women, 8.6 million women (45 percent of the uninsured) would potentially be eligible in that they have income at or below 138 percent of the FPL and are either a citizen or a non-citizen that has resided in the United States for five or more years. Men will also benefit, but not potentially as much as women, in large part because men's family income is higher than women's and will meet the income threshold. There are 7.6 million uninsured men ages 18-65 (and in the country for at least five years) that are eligible for Medicaid expansion, that is 37.5 percent of the 21.7 million uninsured. Ironically, this provision may serve to widen the gender gap in insurance coverage (with men seeing a larger gap).

The Medicaid expansion is also expected to increase usage of those already eligible but not enrolled, including children, because of the state-level outreach efforts to enroll

children, the streamlined application process, and that plans sold in the Exchanges must contract with navigators to conduct outreach and enrollment assistance (Holahan et al. 2012). However, because of the 2012 Supreme Court ruling, which makes the Medicaid expansion separable from the current Medicaid program and sharply reduces the penalties for not opting to expand, many states have indicated they will not move forward on adopting the ACA Medicaid expansion scheduled to begin in January 1, 2014. As of September 30, 2013, there were 25 states that have made a decision not to move forward (Kaiser Family Foundation 2013c).¹⁷ The ability to opt-out, will have a profound effect on women's coverage. Just over forty-six percent of all ACA Medicaid eligible uninsured women and 49.1 percent of eligible men ages 18-64 reside in states that have decided to go forward, with 53.6 percent of eligible uninsured women and 50.9 percent of men live in states deciding not to go forward. Almost one out of every four (24 percent) of *all* uninsured women, regardless of income or citizenship status live in states without the ACA Medicaid extension, which goes into effect in 2014. By comparison, Eighteen percent of all uninsured men live in states not moving forward with Medicaid expansion. These uninsured women (except non-legal residents) can purchase private insurance through Exchanges, although without legislative changes those with income 100 percent below the FPL will not be eligible for any federal credits or subsidies. They will likely be exempt from the individual mandate for financial reasons, leaving a substantial group of economically vulnerable women (and men) still uncovered.

A closer analysis of the demographic characteristics of those living in states moving forward versus those that are not, reveals that poor uninsured black women are the group most adversely affected. Fifty-four percent of all eligible uninsured women (and 51 percent of men) live in states that have decided not to go forward with the Medicaid expansion, but, 66 percent of all uninsured black women ages 18 through 64 with incomes below 138 percent of the FPL and who are not non-citizens residing in the US less than 5 years live in those states. This compares to 57 percent of uninsured white women, 47 percent of Latinas, 38 percent of Asian women, and 44 percent of immigrant women eligible for the Medicaid expansion.¹⁸ This is because uninsured black women are more concentrated in southern and Midwestern states, the ones most likely to not move forward with the Medicaid expansion. This outcome is consistent with the ways in which state-administered means-tested programs have excluded black women historically. There are relatively small disparities among women (and men) by family status and age group.

While the changes to Medicare are slight, they will disproportionately positively affect women. Among Medicaid beneficiaries, women were more likely than men to have three or more chronic conditions, two or more limitations on daily activities, and to suffer from a cognitive/mental impairment (Kaiser Family Foundation 2013e). Most of the conditions require prescription drugs and therefore closing the donut hole will disproportionately benefit women. These same women should also benefit from new efforts to coordinate care.

Employer Responsibility. Employer-sponsored insurance is the leading source of health insurance in America. Sixty percent of men and women ages 18 through 64 had

employer-sponsored insurance in 2011. Over thirty percent of employees, however are not covered by employment-based insurance (31 percent of employed men and 29 percent of employed women). But because non-elder women are more likely to be covered as a dependent when compared to men, this puts women at greater risk of losing coverage if a women becomes widowed or divorced, her spouse loses a job, her spouse's employer drops family coverage or increases premium and out-of-pocket costs to unaffordable levels.

The employer responsibly portion of the ACA does not mandate insurance coverage but charges penalties on employers with more than 50 full-time-equivalent employees when employees receive premium and cost-sharing credits from the government. That is, the employer has to offer affordable insurance that covers the essential health benefits rather than an employee choosing to buy coverage in the Exchange and receive a premium tax credit.¹⁹ Most large employers already offer health insurance, so this portion of the ACA is expected to increase coverage by a small amount. However, there is some concern about large employers moving to more part-time workers to avoid penalties.²⁰ In addition, at least one US large firms (UPS), in anticipation of the ACA and potential mandate costs, has already announced they are dropping family coverage if spouses are employed in firms that offer health insurance to employees. Since women are more likely to be part-time than are men and to use family coverage, these policy shifts by employers will likely disproportionately affect women.

Since small employers are the least likely to cover employees and are offered tax incentives to do so and can join Exchanges to reduce costs, the ACA should increase employer coverage in these firms. Massachusetts saw an increase in employer coverage compared to other states after implementation of its universal health plan (Gruber 2011). Uninsured men are more likely to work for smaller firms than are women, with 66 percent of uninsured men in firms with fewer than 100 employees compared to 55 percent of uninsured women (Authors' calculations using 2012 CPS).

The ACA works to maintain or increase levels of employer-sponsored insurance through competitive pressures through the Exchanges. This puts pressure on large firms to maintain high quality insurance coverage while increased tax incentives for small firms makes group insurance coverage more affordable. If this indeed happens, the impact on women's coverage is likely to be positive but compared to the individual mandate and the Medicaid expansion it will be small.

Individual Mandate. The individual mandate, a key component of the ACA, is intended to fill in the cracks between employer-sponsored insurance and government-based programs. It is targeted to adults under the age of 65 whose family income is above 138 percent of FPL (and therefore not eligible for the Medicaid expansion) without any current employer or private coverage. These plans must include essential benefits, including critical preventative services for women. Of the 19.5 percent of uninsured women between the ages of 18 and 65, 53.6 percent (10.1 million) have incomes above 138 percent of the FPL. Since this is a large group (over half of women ages 18-65), the expansion of the risk pool will allow insurers to include enough healthy individuals to

provide reasonably priced plans. Because the vast majority (9.1 million) of those are in the cost-sharing or premium credit income ranges between 139 and 399 percent of the FPL, they will receive government assistance to help pay for the new costs.

Insurance Market Reforms

The ACA provision to require insurance policies to cover dependent children under the age of 26, implemented in 2010, is estimated to have increased coverage to 3.1 million young adults ages 19-25 (US Department of Health and Human Services 2012).

Women, in particular, will benefit from several aspects of insurance market reforms because prior to the ACA, women were more likely than men to be turned down, charged a higher premium, or have a pre-existing condition that excluded them from health insurance plan (Collins et al. 2012). The law eliminates the gender rating that permitted the individual insurance market in many states (42) to charge women more than men in the same age group for the same insurance policy. It also prohibits insurance companies from denying coverage for a pre-existing condition.²¹ Estimates of the share of women ages 19-64 with a pre-existing conditions in 2009 ranges from 21 to 72 percent, higher than the estimated range for men of 18 to 59 percent (US General Accounting Office 2012: Figure 2). The mandated essential health plan covers a comprehensive set of services that must include maternity, newborn care, pediatric, behavioral health treatment, and prescription drugs. Contraception will be covered with no out-of-pocket costs. Average female out-of-pocket expenses were \$748 in 2010 compared to male annual average of \$619 (calculated from Agency for Healthcare Research and Quality (2013)). The new coverage of critical services for women will very likely lower their out-of-pocket spending costs.

However the exemption of abortion coverage continues to limit women's reproductive health care services and will result in women having to pay for abortion services. The requirement that women receiving a federal subsidy to find an insurance plan that does not include abortion, may result in insurance companies dropping abortion coverage.

Reducing Cost, Improving Delivery of Care

It is expected that healthcare systems reform will address rising costs and the low quality of care. Both men and women will benefit from these changes. The ACA makes the process easy for consumers by creating one site where they can apply and determine eligibility for government and private market plans. The funds dedicated to workforce programs for health professionals will likely benefit more women than men, as women's share of employment in health care services is much higher than men's. There is a specific focus to address the potential nursing shortage (a traditional female occupation). Although many women, especially women of color and migrant women, work in the lower wage occupations within the healthcare systems, new pipeline programs may allow women more opportunities for career growth. Increasingly cultural competency in healthcare delivery systems is important especially with the growth in non-white new eligible enrollees. Improved data collection techniques are important as the country becomes more diverse, women from different cultural and ethnic backgrounds face particular health ailments that are often masked when the data is collected just by sex and

not disaggregated by race/ethnicity or disability, as is the case with the gender differences within racial or other demographic categories. Investments in community health centers will help low-income women and their families receive quality care.

In conclusion, the ACA will bring the US closer to universal coverage and be particularly beneficial to women's health access and outcomes. But, consistent with US social protection policies, the ACA relies heavily on the employment-based system of health coverage for higher income workers with formal employment, individual purchasing power in the marketplace for those without employer-based access, and the state-controlled, means-tested Medicaid program to expand coverage to low-income and poor adults. As it does so, it inherits and builds upon an already highly gendered (and racialized) set of protections.

ACA, recent immigrants and non-citizens

In addition to the potentially large number of poor and low-income uninsured women eligible for Medicaid expansion but in states that have opted out, there is one other large group of women (and men) excluded from the coverage under the ACA – noncitizens. Noncitizens are more likely to be uninsured than citizens, In 2009, 51 percent of noncitizen adults and 38 percent of noncitizen children were uninsured, compared to 18 percent of citizen adults and 8 percent of citizen children (US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation 2012a). Naturalized immigrants can access the benefits of the ACA much like native-born citizens. Legal permanent residents (LPRs) have limited federal coverage and protections. They are subject to the individual mandate and are eligible for the sets of tax provisions and services afforded those purchasing private insurance through the Exchange. Since 1996, legal immigrants have been barred from Medicaid and CHIP during their first five years in the U.S. (although some states have the opted out of this provision) and those provisions still hold. Undocumented migrants, including Deferred Action for Childhood Arrivals (DACA, or often referred to as DREAMers), are exempt from the individual mandate; ineligible for tax credits and subsidies, Medicare, Medicaid, and CHIP; and prohibited from purchasing private health insurance (even at full cost) in the Exchanges. They are eligible for emergency care in community health centers or safety-net hospitals, and if they are low-income can qualify for Emergency Medicaid. Citizen children or LPR children of undocumented parents follow the same rules as adult citizens and LPRs (National Immigration Law Center 2013).

Although eligible migrants will benefit from the expanded coverage and possible tax credits and subsidies, the web of entitlement based on immigration status further limits choices and access for eligible migrants, and can lead to poor health outcomes. Income-eligible immigrant families and children have lower rates of participation in the government means-tested programs like SNAP, TANF, Medicaid, or SCHIP (Capps et al. 2009). The law will further exacerbate the confusion currently experienced by many migrant families in terms of understanding eligibility and complex application processes; and for limited English proficient migrants or those in mixed-status households, these barriers are more pronounced (Perreira & Ornelas 2011).

The purposeful exclusion of undocumented migrants leaves an estimated 11 million people uninsured (Passel and Cohn 2012). Women and children (under 18 years) account for nearly half (47 percent) of the undocumented population, 34 percent and 13 percent respectively (Passel and Cohn, 2012). Undocumented immigrants are overrepresented in low-skill, low-wage jobs (Schenker 2011). In 2010, immigrant men were more likely than native-born men to be employed in production, transportation, and material moving occupations (21 percent), construction (14 percent), and food prep and maintenance work (roughly 8 percent respectively) (US Department of Labor, Bureau of Labor Statistics 2010). Immigrant women were more likely to be employed in service occupations (33 percent) such as domestic work, cleaning maintenance, and healthcare support, and 24 percent were in sales occupations. All these occupations have high health risks that lead to workplace accidents, injuries, and even death (Schenker 2011). Lack of insurance for a population overrepresented in occupations with health hazards will have detrimental effects on their wellbeing.

For immigrant women, in particular undocumented women, the lack of health insurance may lead to effects on children (Perreira & Ornelas 2011). Although migrant children may start out healthier than native-born children, over time good health declines. Compared to other women, undocumented immigrant women have less access to preventive services, start prenatal care later, have fewer prenatal visits, and the use of the prenatal care varies with the availability of publicly funded prenatal programs (American Congress of Obstetricians and Gynecologists 2009). Undocumented pregnant migrant women and children may have access to Medicaid or SCHIP if they reside in a state that provides the expansion. In 2011, only 15 states provided state-only-funded health coverage to some or all qualified immigrants during the five-year ban (US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation 2012b).

The ACA outlines specific verification requirements which include providing a social security number and immigration status when applying for any benefit - Medicaid, CHIP, premium tax credits, and private health insurance in the Exchanges. It also assures that immigration status is to be used for the purpose of determining individual eligibility, a signal that the data cannot be used or shared with immigration authorities. However, lack of knowledge about eligibility requirements and fear of immigration authorities, already limits legal immigrant participation and can only be exacerbated by the law.

Women's health services

The ACA mandates a set of comprehensive services for women that address needs across the life span (except abortions, see below) and that insurance plans must provide and cannot charge a copayments, coinsurances or deductibles for these services. These services include: annual well-woman preventive visits to obtain the recommended preventive services; gestational diabetes screening; Human Papillomavirus Virus (HPV) DNA testing every three years for women who are 30 or older testing every three years; Sexually Transmitted Infections (STIs) counseling; HIV screening and counseling; contraception and contraceptive counseling; breastfeeding support, supplies, and

counseling; and interpersonal and domestic violence screening and counseling (HHS.gov/HealthCare 2011).

However, contraception and abortion services remain contested. ACA provisions allow religious organizations that meet relatively strict definitions of being a religious employer to exempt providing contraception in insurance coverage. However, the insurance issuers of these policies must cover contraception services at no extra cost through policies other than the religious group health plan (US Department of health and Human Services, Health Resources and Services Administration 2013). Religious organizations and private employers argue that the definition of a religious employer is too narrow and there are a growing number of lawsuits to repeal the no-cost sharing contraception coverage benefit that could reach the Supreme Court (National Women's Law Center 2013).

Federal funding for abortions remains illegal (under the 1976 Hyde Amendment), except when the pregnancy is a result of rape, incest, or woman's life is in danger. So that Medicaid cannot cover abortions unless states opt to pay for the procedure using state-funds (only 17 states and the District of Columbia have done so). Under the ACA no state or insurer offering a plan in the Exchange will be required to offer abortion coverage, and each Exchange must include at least one plan that does not cover abortions. States can bar all plans participating in the Exchanges from covering abortions and five states have done so already (Kaiser Family Foundation, 2012a). To comply with the law, state have to estimate the actuarial value of abortion coverage (valued at least \$1 per enrollee per month) and plans that receive federal subsidies would have to collect two premium payments from all enrollees (men and women of all ages) - one payment for the value of the abortion benefit and the other for all other services. Creating this cumbersome and bureaucratic process may lead insurance companies to drop abortion coverage from plans in the Exchanges and further limiting access to abortions. These provisions do not apply to employer-sponsored insurance, unless they are offered through the Exchanges.

The ACA and Human Right Norms

United States political discourse tends to shy away from discussions of human rights. Not surprisingly then, in response to a direct question about health care during one of the 2008 presidential debates, Democratic candidate Barak Obama declared health care to be a right.²² However after the elections and in launching health care reform debates, President Obama's discourse quickly shifted to an emphasis on market-based reforms to address the growing uninsured and rising costs.²³

The ACA moves closer to but does not establish a right to health in the United States. We use the United Nations Office of the High Commission for Human Rights eight key aspects underlying the right to health as our yardstick. The eight aspects are: sufficient availability of health care facilities; health services must be physically and financially accessible; provision should be medically and culturally acceptable (including gender sensitive); be of good quality; be non-discriminatory; include the participation of those being served; accountable provision including for meeting these obligations; and the

presence of the underlying capabilities (such as adequate housing and food) that assure the ability to secure the right to health (United Nations Human Rights n.d. (b)).

The ACA provides improved and a more equitably distributed quality of services by mandating a comprehensive set of services that include reproductive and maternity/infant care services which were traditionally not covered by many insurance plans or cost more to include them. It reforms the health insurance market by eliminating the use of gender rating that charged more for insurance or provided inadequate coverage. The law allocates funding to training a diverse workforce, increased cultural competency training, and requires enhanced data collection and reporting of data on race, ethnicity, sex, primary language, disability status, and urban/rural populations. The ACA establishes the Community-based Collaborative Care Network Program to support consortiums of healthcare providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. These reforms are meant to address the growth in the non-white population and to address current health disparities. The law also creates several organizations and councils to determine the effectiveness of medical treatments, evaluations of public health and wellness programs, and to develop a National Quality Improvement Strategy that prioritizes the delivery of healthcare and improve health outcomes. These investments attend to the underlying determinants of poor health or lack of access to healthcare, increases the availability and accessibility of healthcare systems, and improves the quality of services received.

Still, the ACA falls short of some these key aspects. Although it does move the country toward universal access by mandating that all eligible persons have insurance and expanding government programs, the planned exemptions to the individual mandate will leave millions of people uninsured including those with extreme financial hardship, people with religious objections, American Indians, undocumented immigrants, and incarcerated individuals. The ACA adds to the already existing government-based coverage through Medicaid and Medicare, but still rests heavily on employment-based coverage. Yet, the ACA falls short of requiring all firms to provide employer-sponsored insurance as small firms (fewer than 50 employees) are exempt, allows other small firms (up to 100 employees) to use the Exchanges, and penalizes firms that do not offer coverage and have at least one full-time employee receiving a premium tax credit for purchasing insurance in the market, providing incentives to firms to shift to more part-time employment. There is little in the law about the participation of the public in developing the healthcare interventions, although at local levels hospitals and community-based clinics often have constituent advisory groups. There is little accountability in the law, in terms of violations to the right to health, but it does develop a database to capture and share data across federal and state programs to monitor waste, fraud, and abuse, increase penalties for submitting false claims, strengthens standards for community mental health centers and increases funding for anti-fraud activities. Finally, the ACA does not address the sets of underlying determinants, such as adequate housing, food, or healthy work conditions.

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¹ In 2008, all of the OECD countries except for Turkey, Mexico and Chile had fewer than 5 percent of the population without health insurance coverage for a core set of services. Twenty-one countries had core coverage for 100 percent of the population (OECD 2011a)

² All authors' calculations are derived from the Current Population Survey (CPS) Uniform Data Extracts, Version 0.9.6 of the Annual Social and Economic Supplement (ESEC) prepared by the Center for Economic and Policy Research (2013).

³ The federal government will pay 100 percent of the cost of the Medicaid expansion from 2014 through 2016, the percentage paid is reduced to 90 percent by 2020.

⁴ The legislation calls for expanding coverage to those with family income no more than 133 percent of the FPL, but allows for a 5 percent income disregards, effectively making the family income cut-off 138 percent of the FPL.

⁵ In the United States, the federal poverty line (FPL) varies by family size and composition. The levels were determined in the 1960s and are adjusted every year for inflation.

⁶ Medicaid (Plan D) is a prescription drug plan in which beneficiaries have to pay 25% of the drug costs. The donut hole is a temporary limit on what the drug plan will cover. It is initiated when beneficiaries spend \$2,970 (which includes the cost of the drug on the plan and the individual out-of-pockets costs) on covered drugs, and is lifted when spending reaches \$4,700. While in the coverage gap, beneficiaries have to pay 47.5% of the costs. When above the gap limit, catastrophic coverage is automatically provided assuring small coinsurance or copayments for covered drugs for the rest of the year.

⁷ States can default to the federal government. As of June 2013, 27 states have defaulted (Kaiser Family Foundation 2013d).

⁸ For a list of mandatory Essential Health Benefits (Healthcare.gov 2013) see <https://www.healthcare.gov/glossary/essential-health-benefits/>.

⁹ For example, the ACA reduces Medicare payments to hospitals to account for preventable hospital readmissions and to certain hospitals for hospital-acquired conditions by 1%, prohibits federal payments to states for Medicaid services related to healthcare acquired conditions, eliminates the Medicare Improvement Fund, and reduces the Medicare Part D premium subsidy for those with higher incomes (Kaiser Family Foundation 2013a).

¹⁰ The Organization for Economic Cooperation and Development (OECD) compiles data on social expenditures as a percent of GDP on all OECD countries extending from 1980 through 2012. The ratio of US spending to that of all European members (among the most affluent of the OECD countries) to that of the US, never exceeds .78 (achieved only recently during severe austerity measures) and was at about two-thirds from 1984-2000 (OECD 2013).

¹¹ In the context of the language of social welfare policy regimes, the US conforms with liberal welfare state (Esping-Andersen 1990) and low levels of de-familialism (Esping-Andersen 1999).

¹² States administer the food programs and can supplement these programs as well as have some leeway over some eligibility requirements. Some states also have their own EITC program, most often some percentage of the federal EITC.

¹³ President Franklin D. Roosevelt needed to secure the vote of southern democrats for passage of his signature legislation the Social Security Act of 1935. White southern democrats were not inclined to provide cash assistance to poor white mothers. Only by giving states considerable control of the Aid to Dependent Children program in the legislation, was the President able to secure their votes. The result was that southern black women (where the majority lived at the time) were essentially excluded from the program (Mink 1998).

¹⁴ Pre-ACA report from the Social Security Advisory Board, a body created by Congress and appointed by the President to advise on matters related to Social Security programs, entitled “The Unsustainable Cost of Health Care of Health Care” (2009), portends the importance of health reform in terms of tackling costs (one of President Obama’s goals with the ACA). That document reports estimates that without changes, total health care costs would double between 2008 and 2018.

¹⁵ Unless otherwise noted, all data used in this section and the next were derived by the authors using 2012 ASEC Supplement to the Current Population Survey, using the Uniform Extracts prepared by the Center for Economic and Policy Research (2013).

¹⁶ Respondents can report more than one type of insurance coverage over the year. To eliminate overlap, the categories represented in the figure are: any employer-sponsored coverage; Medicaid, no employer-sponsored coverage; other public, no employer-sponsored; and privately insured, no public insurance.

¹⁷ The states not moving forward at this point are: Alaska, Alabama, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming (Kaiser Family Foundation 2013c)

¹⁸ Eligible black men are also very over-represented in states not currently expanding Medicaid, with 65 percent living in those states, compared to 45 percent of Latinos, 31 percent of Asian, and 44 percent of immigrant men.

¹⁹ See Kaiser Family Foundation (2103b) for a flow chart on employer penalty rules.

²⁰ Using simulations models, Blumberg, Holahan, and Buettgens (2103) estimate that it will increase coverage by 0.1 percent while Eibner, Hussey, and Girosi (2010) find that firms with more than 50 employees will increase coverage by 3.5 percent.

²¹ Insurance companies had the right to deny coverage or charge a higher premium to new clients with any pre-existing condition, defined by the insurer. These could include a health condition for which someone is currently being treated or had in the past. The General Account Office estimated that between 36 and 122 million individuals have a pre-existing condition, the common reported conditions were hypertension followed by mental health disorders, diabetes and asthma (US Government Accounting Office 2012).

²² During Presidential debates in 2008, in response to a question asking if health care in America is a privilege, right, or a responsibility, then candidate Obama replied, “Well, I think it should be a right for every American” (LA Times October 7, 2008).

²³ This is the approach President Obama presents in his 2010 State of the Union Address (Whitehouse.gov 2010).