

DISCUSSION PAPER

EXPANDING HEALTH-CARE ACCESS IN THE UNITED STATES:

Gender and the Patchwork 'Universalism'
of the Affordable Care Act



No. 2, July 2015

RANDY ALBELDA AND DIANA SALAS CORONADO

FOR PROGRESS OF THE WORLD'S WOMEN 2015-2016

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SUMMARY

The United States has never assured the human right to health, including the right to the highest attainable standard of physical and mental health and access to all medical services. As recently as 2012, 15.4 per cent of the US population was uninsured. While there is some public financing of health care, mainly for older people and low-income children, the country largely relies on private health insurers and providers using a decentralized and lightly regulated market-based system. The majority of non-elder adults get their health insurance through voluntarily provided employer-based plans. The 2010 passage of the Patient Protection and Affordable Care Act (usually referred to as ACA or ‘Obamacare’) will bring the United States closer to universal health coverage when fully implemented. This paper focuses on the ways in which women have been and will be impacted by the ACA. The ACA’s three main goals of expanding access, increasing consumer protections and reducing costs while increasing quality of services will improve coverage, access to services and types of services that benefit women (and men). The main mechanisms include increased access to health insurance coverage through the expansion of Medicaid (government-sponsored health insurance for low-income children and adults) and the state-based health-care exchanges that began in 2014; mandatory coverage of essential health benefits including many reproductive and family planning services; no cost preventative medical services; regulation of previous discriminatory practices based on gender and health status; better coordinated care for pregnant women and mothers on Medicaid and all women using Medicare (government-sponsored health insurance for some disabled people and almost all people aged 65 and older); and improved drug prescription coverage for those on Medicare. However, universal coverage remains illusive due to employer-based insurance coverage that allows firms to make decisions about coverage type, including whether they will cover contraception; pre-existing federal funds restrictions on abortion services extending to a larger group of women (those receiving federal subsidies and credits that help make privately-purchased insurance

affordable); a 2012 Supreme Court decision that allows states to ‘opt out’ of the Medicaid extension; states restrictions on private insurance coverage and plans offered through the exchanges for abortion services; and the planned exclusion of undocumented immigrants and those who have not been in the country for at least five years. This patchwork universalism is the result of political decisions to extend rather than transform the current health-care system and as such reproduces many of the previously existing problems of uneven costs and coverage. The paper argues the ACA is consistent with other sets of US social welfare and labour market regimes that stratify access to social protections by income, race/ethnicity and gender as well as provide individual states with administrative and policy authority. It describes the pre-ACA health-care system and documents the gaps in 2012 health insurance coverage for women and men aged 18–64 by race/ethnicity, citizenship status, age group and family status. It finds men were less likely to be covered than women, primarily because fewer men are eligible for Medicaid, a programme that largely serves low-income families with children. The percentage of women and men with employer-based coverage was almost identical (at just under 60 per cent), although women were much more likely to be covered through spouses’ employer than were men. There were also large gaps in health insurance coverage among women, with more white, native-born, older and married women being insured than other women. The paper goes on to assess the potential impacts of the extension of health insurance under the key provisions of the ACA. Using health coverage data from 2012, it estimates the likely impact of the decision of 24 states to ‘opt out’ of the Medicaid expansion. This provision extends government-financed health insurance to most adults with an income below 138 per cent of the US poverty income threshold, greatly expanding coverage to low-income adults. Yet, among those aged 18–64, 23 per cent of all uninsured women and 17 per cent of all uninsured men will remain uncovered due to states opting out. Overall, the passage of ACA will vastly improve health-care coverage in the United States; however,

the over-dependence on market-based mechanisms, the historic and contemporary limits to social welfare provisions for the most vulnerable (based on income, racial/ethnic and gender) and an important but incomplete overhaul of private insurance

markets will continue to leave millions of people uninsured and will not correct most of the inherited disparate out-of-pocket costs (premiums, deductibles and co-payments) paid by individuals that vary by employer and/or state level insurance policy decisions.

RÉSUMÉ

Les États-Unis n'ont jamais veillé au respect du droit humain à la santé, y compris du droit au meilleur état de santé physique et mentale et à l'accès à l'ensemble des services médicaux. Aussi récemment qu'en 2012, 15,4 pour cent des habitants des États-Unis ne bénéficiaient toujours pas d'une assurance. Bien qu'il existe un certain niveau de financement public des soins de santé, principalement destiné aux personnes âgées et aux enfants issus de familles à revenus faibles, les États-Unis s'appuient en grande partie sur les assureurs et les prestataires de soins de santé privés en se servant d'un système décentralisé et faiblement réglementé, fondé sur le marché. Les personnes du troisième âge mises à part, la majorité des adultes sont assurées par le biais de régimes d'assurance volontaires de leur employeur. Une fois pleinement appliquée, la Loi étasunienne sur la protection des patients et les soins abordables (Patient Protection and Affordable Care Act) (souvent visée par l'acronyme ACA ou surnommée « Obamacare ») votée en 2010 rapprochera les États-Unis de la couverture maladie universelle. Cette étude se penche sur la façon dont l'ACA a eu et aura un impact sur les femmes. Les trois principaux objectifs de l'ACA qui consistent à élargir l'accès, accroître les protections dont le public peut se prévaloir et réduire les coûts tout en améliorant la qualité des services amélioreront la couverture, l'accès aux services et les types de services qui profitent aux femmes (et aux hommes). Ces principaux mécanismes comprennent un accès amélioré à la couverture de l'assurance santé par le biais de l'extension du programme Medicaid (assurance santé parrainée par le gouvernement pour les enfants et les adultes qui ont de revenus faibles) et des comptoirs de soins de santé (appelés health care exchanges) lancés dans les états-mêmes en 2014 ; une couverture obligatoire des soins de santé de base, y compris des services de planning familial et de santé reproductive et des services de médecine préventive gratuits ; la réglementation des pratiques autrefois discriminatoires fondées sur le sexe et l'état de santé ; une meilleure coordination des soins pour les femmes enceintes et les mères dans le cadre de Medicaid et pour toutes les femmes inscrites auprès de Medicare (assurance santé parrainée par le

gouvernement pour certaines personnes handicapées et presque toutes les personnes âgées de 65 ans et plus) ; et une meilleure couverture de la prescription des médicaments pour les personnes qui bénéficient de Medicare. Cependant, ce programme ne permet pas d'atteindre une couverture universelle, car l'ACA continuera de ne pas pourvoir aux besoins de santé de nombreuses femmes et de nombreux hommes, tout particulièrement parmi ceux et celles qui sont vulnérables sur le plan économique et les sans-papiers. La couverture universelle demeure toujours illusoire en raison de la couverture d'assurance qui s'obtient par le biais de l'employeur et permet aux entreprises de prendre les décisions concernant le type de couverture, y compris l'offre ou non de méthodes contraceptives ; des restrictions placées sur les fonds fédéraux préexistants concernant les services d'avortement élargis à un groupe de femmes plus large (celles bénéficiant de crédits et de subventions fédérales qui contribuent à rendre l'achat d'assurances privées abordable) ; d'une décision de la Cour suprême en date de 2012 qui donne la possibilité aux États de ne pas participer à l'extension de Medicaid ; des restrictions que les États imposent aux régimes et à la couverture d'assurance privés offerts par le biais des prestataires en ce qui concerne les services d'avortement ; et de l'exclusion prévue des sans-papiers et des immigrés qui résident dans le pays depuis moins de cinq ans. Cet « universalisme hétérogène » est le fruit de décisions politiques visant à élargir plutôt qu'à transformer le système de soins de santé actuel et, en tant que tel, reproduit nombre des problèmes concernant l'inégalité des coûts et de la couverture qui existaient déjà au sein du système décentralisé, complexe et dépourvu de coordination. Nous faisons valoir que l'ACA est conforme à d'autres mesures d'aide sociale aux États-Unis ainsi qu'aux régimes du marché du travail qui stratifient l'accès aux mesures de protection sociale en fonction des revenus, de la race/ethnicité et du sexe, tout en dotant les États individuels de pouvoirs sur le plan administratif et en matière de politiques. Nous décrivons le système de soins de santé avant l'ACA qui dépendait fortement de la couverture volontaire obtenue par le biais de

l'employeur et était complétée par le programme fédéral Medicare et les programmes Medicaid d'État, et qui laissait une personne sur cinq âgée de 18 à 64 ans sans couverture. Nous recensons les lacunes de la couverture de l'assurance santé 2012 pour les hommes et les femmes appartenant à cette tranche d'âge en fonction de leur race/ethnicité, citoyenneté, tranche d'âge et état civil avant la mise en œuvre des principales dispositions de l'ACA. Nous découvrons que les hommes sont moins susceptibles de bénéficier d'une couverture que les femmes, principalement en raison du fait que moins d'hommes remplissent les critères pour bénéficier de Medicaid, un programme destiné en grande partie aux familles à faibles revenus qui ont des enfants. Le pourcentage de femmes et d'hommes qui bénéficient d'une couverture par le biais de leur employeur est presque identique (légèrement inférieur à 60 pour cent), bien que le nombre de femmes couvertes par le biais de l'employeur de leur époux est beaucoup plus élevé que ne l'est celui des hommes à travers leurs épouses. Nous révélons également des lacunes importantes de la couverture de l'assurance santé parmi les femmes, les femmes blanches nées aux États-Unis, plus âgées et mariées ayant plus de chance de bénéficier d'une assurance que les autres. Enfin, nous évaluons les impacts possibles de l'extension de l'assurance santé en vertu des principales dispositions de l'ACA. À l'aide des données relatives à la couverture des soins de santé de 2012,

nous estimons l'impact probable qu'aura la décision des 24 états de ne pas participer à l'extension de Medicaid. Cette clause élargit l'assurance santé subventionnée par l'État à la plupart des adultes ayant des revenus au-dessous de 138 pour cent du seuil de pauvreté aux États-Unis, élargissant ainsi fortement la couverture aux adultes ayant de faibles revenus. Parmi les personnes âgées de 18 à 64 ans, nous découvrons que 23 pour cent de toutes les femmes sans assurance et 17 pour cent de tous les hommes sans assurance ne bénéficieront toujours pas d'une couverture d'assurance, et ce, en raison de la décision de ces 24 États de ne pas élargir la couverture de Medicaid. Dans l'ensemble, le vote de l'ACA améliorera grandement la couverture des soins de santé aux États-Unis. Cependant, la dépendance excessive vis-à-vis des mécanismes fondés sur les marchés, les restrictions historiques et contemporaines aux dispositions de l'aide sociale pour les plus vulnérables (en fonction du revenu, de la race/ethnicité et du sexe) et une refonte importante mais incomplète des sociétés privées d'assurance continueront de laisser des millions de personnes sans assurance et ne corrigeront pas la plupart des frais complémentaires disparates hérités du système précédent (primes, franchises et quotes-parts) et versés par les particuliers, qui varient d'un employeur à l'autre et/ou en fonction des décisions de politique prises par chaque état en matière d'assurance.

RESUMEN

Los Estados Unidos nunca han garantizado el derecho humano a la salud, incluido el derecho al disfrute del más alto nivel posible de salud física y mental y el acceso a todos los servicios médicos. Hace solo unos años, en 2012, el 15,4 por ciento de su población carecía de seguro médico. Si bien es cierto que el sector público destina un determinado volumen de fondos para financiar la atención sanitaria, especialmente para las personas de edad y las y los niños de familias de bajos ingresos, el modelo estadounidense depende en gran medida de los proveedores y las aseguradoras médicas privadas, que utilizan un sistema descentralizado y poco regulado basado en el mercado. La mayoría de las y los adultos que no han alcanzado aún la edad avanzada cuentan con seguros médicos a través de planes que proporcionan los empresarios de forma voluntaria. La aplicación completa de la Patient Protection and Affordable Care Act (Ley para la atención asequible y la protección del paciente, denominada normalmente ACA u “Obamacare”), aprobada en 2010, acercará a los Estados Unidos a la cobertura sanitaria universal. Esta investigación se centra en los efectos que ha tenido y tendrá la ACA sobre las mujeres. Los tres principales objetivos de la ACA, a saber, ampliar el acceso, aumentar las protecciones del consumidor y reducir los costos propiciando al mismo tiempo una mayor calidad de los servicios, mejorarán la cobertura, el acceso a los servicios y los tipos de servicios que benefician a las mujeres (y los hombres). Algunos de los mecanismos más importantes utilizados para tal fin son: la mejora del acceso a la cobertura sanitaria mediante la ampliación del programa Medicaid (seguro médico de financiación gubernamental para niños y adultos de familias de bajos ingresos) y los intercambios de atención sanitaria con base estatal que comenzaron en 2014; la cobertura obligatoria de las prestaciones médicas básicas, incluidos numerosos servicios de salud reproductiva y planificación familiar; servicios médicos preventivos gratuitos; la regulación de las antiguas prácticas discriminatorias basadas en el género y en el estado de salud; una atención mejor coordinada a las mujeres embarazadas y las madres en Medicaid

y a todas las mujeres que utilizan Medicare (seguro médico de financiación gubernamental para algunas personas con discapacidad y casi todas las personas de 65 años o más); y una mejora de la cobertura de los medicamentos con receta para las personas cubiertas por Medicare. Sin embargo, no se cumple el objetivo de cobertura universal ya que la ACA continuará ignorando las necesidades sanitarias de un gran número de mujeres y hombres, especialmente de los inmigrantes indocumentados y económicamente vulnerables. La cobertura universal continúa siendo una realidad ilusoria debido a los factores siguientes: la participación de las empresas en la cobertura de los seguros, que permite que las empresas decidan el tipo de cobertura, incluida la anticoncepción; restricciones financieras federales preexistentes que afectan a un grupo mayor de mujeres (aquellas que reciben subsidios y deducciones federales que les ayudan a poder asumir un seguro privado); una decisión de 2012 de la Corte Suprema por la que se permite a los estados decidir si aceptan la ampliación de la cobertura de Medicaid; restricciones estatales a las coberturas y los planes de seguros privados que se ofrecen mediante intercambio para los servicios de aborto; y la exclusión prevista de las y los inmigrantes indocumentados y las y los inmigrantes que no han estado en el país durante al menos cinco años. Esta universalidad fragmentada es el resultado de las decisiones políticas, que pretenden ampliar el sistema de atención sanitaria actual en lugar de transformarlo, y por ello reproduce muchos de los problemas relacionados con la disparidad de la cobertura y los costos ya existentes en el complicado y descoordinado sistema descentralizado anterior. Los autores del estudio argumentan que la ACA es coherente con otros escenarios de regímenes de bienestar social y mercado laboral de los Estados Unidos que estratifican el acceso a las protecciones sociales según los ingresos, la raza/etnia y el género y que confieren autoridad administrativa y política a cada estado. Además, se describe el sistema de atención sanitaria anterior a la ACA, que dependía en gran medida de la cobertura voluntaria basada en el empleo y se

complementaba con el programa Medicare de base federal y los programas Medicaid dirigidos por los estados, que dejaban sin cobertura sanitaria a una de cada cinco personas de entre 18 y 64 años. El informe documenta asimismo las deficiencias existentes en 2012, antes de la aplicación de las disposiciones fundamentales de la ACA, en la cobertura de los seguros médicos para las mujeres y los hombres incluidos en este grupo de edad, en función de la raza/etnia, el estado de ciudadanía, el grupo de edad y la situación familiar. Se observa que los hombres tienen menos probabilidades que las mujeres de recibir cobertura, en gran parte porque el número de hombres que cumplen los requisitos para optar a Medicaid, un programa que se ocupa principalmente de familias de bajos ingresos con niños, es menor. El porcentaje de hombres y mujeres con cobertura a cargo de la empresa es prácticamente el mismo, ligeramente por debajo del 60 por ciento, aunque las mujeres tienen más probabilidades de formar parte de este grupo a través del empleador de su cónyuge. También se detectan lagunas importantes en la cobertura de los seguros médicos de las mujeres, con un porcentaje de cobertura mayor entre las mujeres blancas, casadas y de más edad que han nacido en los Estados Unidos. Por último, se valoran las repercusiones potenciales de la ampliación de los seguros médicos en el marco de las disposiciones más importantes de la ACA.

Basándonos en los datos de cobertura sanitaria de 2012, los autores calculan el efecto probable de la decisión adoptada por 24 estados de autoexcluirse de la ampliación de Medicaid, que incluye en el seguro médico de financiación gubernamental a la mayoría de las y los adultos cuyos ingresos no alcanzan el 138 por ciento del umbral nacional de pobreza, lo que supone una importante ampliación de la cobertura a adultos con bajos ingresos. Se observa que, debido a la decisión de esos 24 estados de no ampliar la cobertura de Medicaid, el 23 por ciento de las mujeres sin seguro y el 17 por ciento de los hombres sin seguro del grupo de edad de 18 a 64 años continuarán careciendo de cobertura sanitaria. En términos generales, la aprobación de la ACA mejorará enormemente la cobertura sanitaria en los Estados Unidos. No obstante, la dependencia excesiva de los mecanismos basados en el mercado, los límites históricos y contemporáneos que se aplican a las personas más vulnerables (en función de los ingresos, la raza/etnia y el género) para acceder a las prestaciones de asistencia social, y la importante, aunque incompleta, revisión de los mercados de seguros privados continuarán dejando a millones de personas sin cobertura y no corregirán la mayoría de los dispares costos adicionales heredados (primas, desgravaciones y copagos) que deben abonar los individuos y que varían según el empleador, las decisiones estatales

1.

INTRODUCTION

Access to health care is a vital basic need that enhances human capabilities on many levels. 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 and is enshrined in international human rights treaties.

However, the United States has never assured health-care access as a human right. As recently as 2012, 15.4 per cent of the US population did not have health insurance (authors' calculations 2014).¹ This coverage gap distinguishes the United States from most affluent countries that have had universal health-care coverage for decades. While there is some public financing of health care, mainly for seniors and low-income children, the country largely relies on private health insurers and private health providers using a predominately market-based system that is decentralized and lightly regulated. This has left many people uninsured, allowed insurers considerable leeway on what patients and procedures to cover and given providers the ability to set prices for their services.

On 23 March 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. Once fully implemented, the ACA promises to vastly improve key dimensions of health-care provision by expanding coverage for both women and men, establishing measures that require health insurers to provide coverage for persons with pre-existing health conditions, mandating free preventative care, expanding coverage of reproductive health services and implementing cost-containment

measures in publicly financed plans. The provisions of the ACA are being phased in over a five-year period, with the most extensive coverage provisions only coming into effect in 2014. However, many of those provisions, especially the ones that provide affordable health insurance to the poorest residents and coverage of women's reproductive health care, have faced and continue to face legal challenges.

The key mechanisms for expanding coverage are mandating uninsured individuals to purchase private plans through state-level or federally facilitated marketplace exchanges, penalizing larger employers that do not provide employees with affordable insurance plans and expanding the publicly financed, state-administered Medicaid programme to cover low-income adults. To assure affordability, the federal government will provide tax credits and subsidies to small employers and individuals who cannot afford to purchase private insurance. (For more detail, see box 6-1)

This paper argues that, while promising, the ACA is not an overhaul of health-care provision in the United States and as such will continue to leave the health-care needs of many women (and men) – especially those most economically vulnerable – unmet and bearing high costs. This is because the ACA builds on the current complex health insurance and health-care services system already in place. This system conforms with other US social policies that rely heavily in their implementation on market-based mechanisms and on individual states that have long embodied institutional gender, racial, ethnic and income-based biases. Conservative state and corporate legal challenges have already successfully denied insurance coverage and fundamental reproductive health care to substantial numbers of women. So that while the ACA certainly will expand access to basic health-care services, especially for women, it falls short of providing universal coverage and fulfilling a commitment to health care as a human right.

¹ All authors' calculations are derived from the Current Population Survey (CPS) Uniform Data Extracts, Version 0.9.7 of the Annual Social and Economic Supplement (ESEC) prepared by the Center for Economic and Policy Research (2014).

2.

WOMEN AND THE ACA: PATCHWORK PROMISES AND PITFALLS

The ACA makes important changes to the US health-care system 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 effects on women. The most important ones are:

- Increased access to affordable health insurance through the expansion of Medicaid (government health insurance for low-income individuals and children) to all adults with incomes below 138 per cent of the federal poverty income threshold (\$19,530 for a family of three in 2013);
- Increased access to affordable health insurance through private insurance through exchanges;
- Mandatory insurance coverage for essential health benefits including 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. However, abortions were explicitly excluded from the list of essential benefits;
- 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 (senior government insurance programme) will receive better-coordinated and comprehensive care;
- Increased drug prescription coverage for those on Medicare (closing the 'donut hole'²); and
- Possible indirect benefits from better health-care 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 complicated and uncoordinated system, it will reproduce many of the same problems of uneven costs and coverage. The following aspects of the implementation of the ACA will adversely impact some of the most vulnerable women and fall short of the promise of universal coverage:

- Employer-based insurance coverage allows firms to make decisions about the type of coverage to provide workers, including if they will make family coverage available. A recent Supreme Court decision also allows firms to decide whether they will allow coverage for contraception. As a result there will remain a

² The 'donut hole' refers to the coverage gap that currently exists for Medicare-related drug prescriptions (see box on Key Provisions).

great deal of variability in the plans employers offer and how much of the premium they pay.

- In part due to a Supreme Court ruling challenging the ACA, states are provided with substantial control over Medicaid expansion decisions. In 2014, the first year of implementation, 24 states opted out of this expansion even though the federal government initially pays for all of the new costs (which will drop in increments to 90 per cent by 2020).
- Insurance coverage for abortions services has become more restricted through the ACA as federal funds cannot be used. Nine states restrict insurance coverage for abortion in all private insurance plans, while 25 states restrict abortion

services plans offered through the exchanges (Guttmacher Institute 2014).

- Many immigrants will remain uncovered by the ACA, including those who are not documented as well as those who have not been in the country for at least five years.

The implications of these changes are elaborated in section 5 of this paper. In order to understand the effects, we first explain a bit more about the US health-care system, how it has operated within the larger framework of US social policy and social protections, and the unevenness of coverage prior to the ACA.

3.

SOCIAL PROTECTIONS IN THE UNITED STATES: THE GENDERED AND RACIAL WELFARE STATE AND LABOUR MARKET REGIMES

Access to affordable health care is part and parcel of any country's social protection system. To best understand the importance of the ACA as well as the ways in which gender relations (as well as race/ethnicity and income) have helped shape and may be shaped by the legislation, it is important to provide some background on the US health-care system in the context of the larger social protection policy approach (or liberal welfare state regime). Because the vast majority of people receive their health insurance through employment and employer-based insurance plans, it is also important to place the ACA within the context of US labour market regimes. Together, this brief overview of US welfare state and labour market regimes provides a framework for understanding the impacts of the ACA on women.

US health-care provision

Comparing health-care systems within welfare state regimes across countries is a difficult task, since few of these systems fit 'ideal' types (Moran 1999; Bambra 2005a). One issue is that health care is a service, most social protection policies entail income transfers, and the underlying mechanisms for delivery of services may differ generally from those of redistribution (Bambra 2005b). Health-care service delivery entails several components, including the institutional relationship around financing, provision and regulatory aspects. Often these axes of comparison do not all neatly map onto particular welfare regimes or state types as identified in the literature. However, one country whose health-care delivery system does tend to fit into these ideal types is the United States. Recent analytical and empirical examinations find that the

US health-care model is one that is financed through insurance fees provided privately with the state playing a minimal role in regulating patient, provider and insurance contracts while medical providers maintain a good deal of autonomy (Beckfield et al. 2013). This results in limited public access, little public control of costs or hospitals and few government constraints on medical innovation (Burau and Blank 2006) The system has been referred to as the Bismarck system (Beckfield et al. 2013), while on the Organisation for Economic Co-Operation and Development (OECD) spectrum it conforms with consumer sovereignty. Moran creates a typology in which he calls this model the supply health-care state (Moran 1999).

Using Moran's (1999) comparative typologies, Burau and Blank (2006) find that the United States is one

of the few countries that uniformly fits this model. Bambra (2005a; 2007) measures the degree to which health-care services may be decommodified – or left out of the realm of being employment-based – which is the basis for Esping-Andersen’s classification of welfare state regimes. She finds the United States ranks the lowest among the 18 OECD countries, placing it squarely within the liberal welfare state regime, despite finding other Anglo-Saxon countries also classified as liberal regimes by Esping-Andersen scored much higher than those countries typically placed in the conservative or corporatist regimes considered to have deeper welfare state provisions. Her measures are based on private expenditures as a percentage of gross domestic product (GDP), private hospital beds as a percentage of total bed stock and public health-care system coverage. In short, there seems to be convergence in thinking about the US health-care system as one that relies heavily on market-driven financing, provision and regulation of services. Weiner et al. (2008) report that the United States spends 15.4 per cent of GDP on health (the highest among the 22 developed and developing countries they examined), with government expenditure accounting for 44.6 per cent of that. Just over one out of every four persons (26.6 per cent) were covered by government or national insurance.

Access to health-care insurance in the United States comes through three avenues, with the heaviest reliance on private insurance to ensure access. And while other countries rely on private insurance as well (notably Canada, France, Germany and Japan), this access is not collectivized through social insurance schemes, nor is it universally guaranteed. The first and most common form is voluntarily provided and subsidized employer-based insurance (referred to here as employment-based insurance) using group coverage.³ Employers decide whether they will provide insurance and pick the set of packages offered for employees to enrol in and the percentage of the premium employers will pay. In 2012, 54.9 per cent of the population relied on employment-based

insurance (sometimes in conjunction with other forms of insurance). The second most common form of access is through a government plan. Almost all persons 65 and older are covered through Medicare (although many supplement that with private insurance) and most children are covered through the Medicaid state CHIP programme. The latter programme also covers some but not all poor adults without private insurance. Veterans can also be covered by government-financed and provided health care. In total, almost one third (32.6 per cent) of all persons have some government plan (again, this can be in conjunction with other plans). The third form is obtaining health insurance directly in the private market (referred to as directly purchased insurance), which was held by 9.8 per cent of the population in 2012 (DeNavas-Walt et al. 2013:8).

In part to reduce costs and improve quality of care, employers, insurers and the federal government have moved toward providing care through managed care organizations such as health maintenance organizations and preferred provider organizations (Weiner et al. 2008). This is a system in which insurance companies direct patients toward provider networks (with negotiated fees for service) that create a set of financial incentives for providers as well as patients (such as high deductibles and co-payments) to use care sparingly or efficiently, which also places an increased financial burden on individual consumers.

This patchwork, market-oriented health-care system leaves many without health insurance as well as people with high out-of-pocket medical expenses. In 2012, the average medical out-of-pocket expense was \$4,050 (authors’ calculations using the Current Population Survey, CPS). On average, employers that provide health insurance pay 69 per cent of the premium (US Department of Labor 2014.) Seventy-two per cent of workers enrolled in a plan have a deductible, which averaged \$1,097 in 2012 (Kaiser Family Foundation 2012c). One quarter of Medicare recipients purchase supplemental insurance to cover costs Medicare does not, such as deductibles, co-payments and certain services (Kaiser Family Foundation 2014a). Further, prior to the ACA, private insurers in the direct purchase market had broad authority to accept, reject and set different rates

³ 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 favourable tax treatment of employment-based health insurance help account for its continued usage.

for applicants, to decide which medical procedures and medications they would cover at what prices, and to set life-time spending caps. Thus even those with insurance could find themselves uncovered for needed medical services.

Welfare state policies

The distribution of those who are uninsured is not random, nor is the particular health-care system that has developed. To better understand the gendered (and racial) implications of the ACA it is useful to place the US health-care system in the framework of the country's social protection policies as well as labour market regime.

Compared to other affluent countries, the US government plays a smaller role in cushioning workers from loss of income due to old age, disability, unemployment, and family responsibilities (helping families pay for care of young children).⁴ Instead, individual families rely more heavily on their own resources, especially earnings and unpaid family time. For example, while US total social expenditures as a percentage of GDP are comparable to many other developed countries, the composition differs – with much higher levels of private market expenditures, as depicted in Figure 3a. In terms of health-care spending, the United States is an outlier in terms of both the percentage of GDP spent on health care and also that the majority of expenditure is private (see Figure 3b).

The United States also lags in employment and government policies that support paid and unpaid care work, with the 2007 US public contribution at 1.18 per cent of GDP on child payments and allowances, parental leave benefits and childcare support compared to the OECD average of 2.19 per cent (OECD 2011b, Figure 1.11).⁵

4 The OECD compiles data on social expenditures as a percentage 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) never exceeds .78 (achieved only recently during severe austerity measures) and was at about two thirds from 1984–2000 (OECD 2013).

5 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).

The United States has a three-tiered social protection system (Albelda 2011). The first tier includes government-mandated, employment-based programmes. The key programmes in this tier include Unemployment Insurance, Old Age, Survivor's and Disability Insurance (commonly called Social Security) and Medicare. These social insurance programmes are primarily financed through payroll (social insurance) taxes, with eligibility linked to employment. The second tier consists of voluntary employer-provided protections including contributions to health insurance coverage and retirement plans as well as paid time off for vacations, own illness or parental/maternity leave.⁶ Employers pay for paid sick days, while all the others are typically paid through payroll contributions by employers and employees. The third social protection tier includes 'safety net' (anti-poverty) programmes, mostly financed with general revenues, and covers programmes that provide food, housing, childcare assistance and income support (including refundable tax credits) for poor individuals or families, and Medicaid. These means-tested programmes developed separately over time and are housed in an array of government agencies with differing eligibility criteria (Albelda 2011). In general, means-tested programmes are less generous than government employment-based programmes, quite often stigmatized and frequently do not reach eligible families (Albelda and Boushey 2007). The government programmes (Medicare and Medicaid) are explained in more depth in the Appendix).

There is an additional complicating aspect of US social protection policies, and that 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 programmes are federal programmes (although some are administered at the state level),

6 Five states (California, Hawaii, New Jersey, New York and Rhode Island) have mandatory temporary disability wage replacement programmes covering own health. Three of these (California, New Jersey and Rhode Island) have extended that to include family leave. One state (Connecticut) and several cities require most (but not all) employers to provide paid sick time.

FIGURE 3A

Public and private social expenditure* in percentage of GDP, 2009

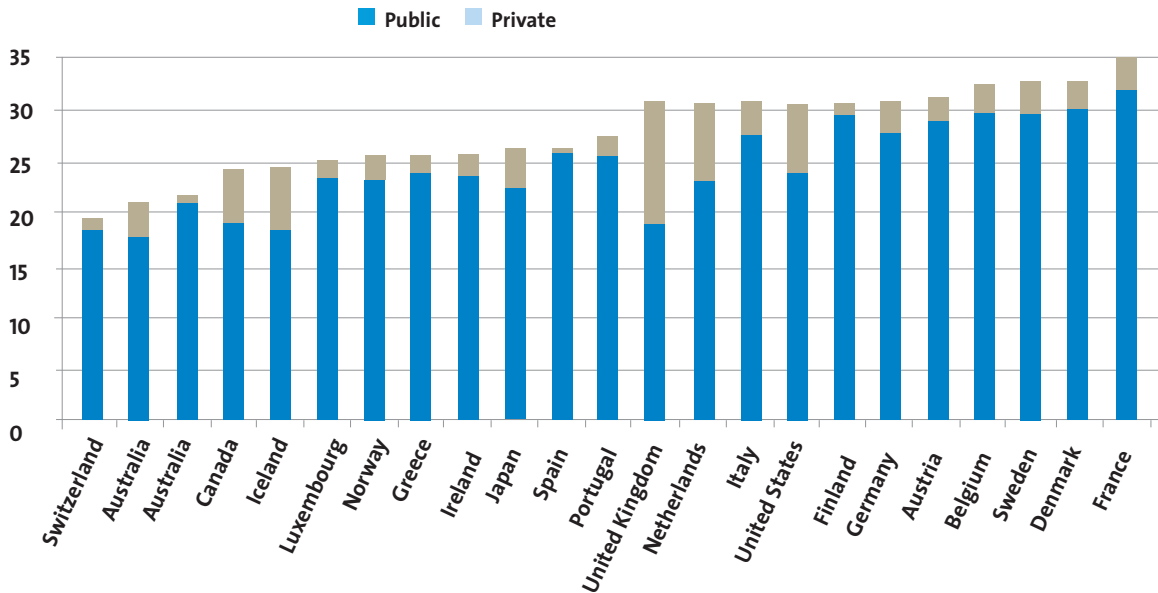
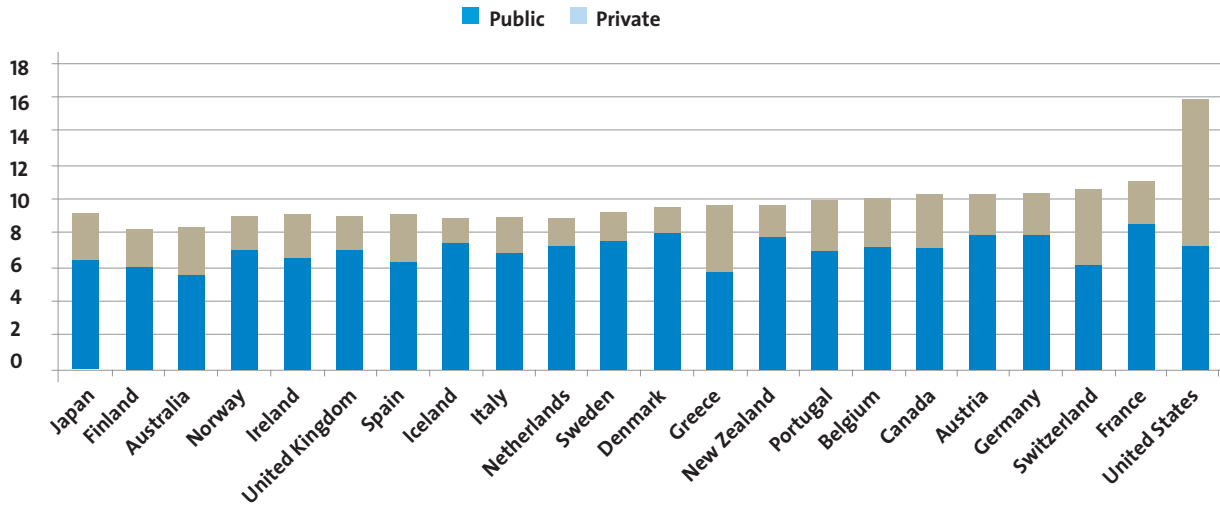


FIGURE 3B

Public and private health-care expenditure in percentage of GDP, 2008



Sources: OECD 2011a and 2013.

*Includes spending on old age, survivors, incapacity-related benefits, health, family, active labour market programmes, unemployment, housing and other social policies.

with uniform benefits and eligibility criteria across the states.⁷ The rest of the programmes 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, TANF) and Medicaid are jointly financed by state and federal governments and 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 programmes, there is enormous diversity in the type and amount of provision of social protections, especially for low-income people and families, across employers and across states.

Historically, race and gender have been very important factors in shaping the benefit levels, state-level authority and inclusion criteria for social protection programmes. Mandatory and voluntary employment-based benefits were initially structured to support white married male breadwinners (and through them their wives), while means-tested programmes were tailored for unmarried mothers (Orloff 1993; Albelda 2011). The various tiers of protection also carry very different notions of deservedness, which serves to reproduce unequal gender relations (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 health care and social security income coverage through husbands. Means-tested programmes that disproportionately serve people of colour and/or single mothers are the set of social protections most likely to give states considerable discretion, as is the case with poor mothers' income support and Medicaid (Mettler 1998). States determine benefit levels, eligibility levels, where to locate administrative offices and the levels of

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

discretion exerted by individual case-workers. This allows states to shape their programmes' 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 programme for poor mothers with children in 1935 (Gordon 1994).⁸ State discretion has resulted in a higher likelihood that non-white populations will be precluded from those programmes (Quadagno 1994; Mink 1998; Ward 2005; Schram et al. 2010). Civil rights and feminist struggles have reduced many of the formal mechanisms of exclusion, but gender, race/ethnicity and income still remain important signifiers and dividing points in contemporary debates on social protection policies. The ways in which state authority has been exerted and resulted in particular exclusionary patterns is especially pronounced in the rollout of the ACA, as will be shown in a later section, with 24 states opting out of the Medicaid expansion and 27 opting out of establishing state-level marketplace exchanges (relying on federal-facilitated exchanges).

Labour market mechanisms

For most families, employment is the most important source of income for social provisioning. This is especially relevant in the United States given the high reliance on private sources for social protection expenditures. Compared to other affluent countries, it places a heavy reliance on competitive labour and product markets and has lower union density and weaker collective bargaining structures (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. There is minimal labour market regulation, including voluntary employer provisions of paid time off and health insurance.

8 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 black mothers. Only by giving states considerable control of the Aid to Dependent Children programme 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 programme (Mink 1998).

Access to employment and the nature of jobs have also been shaped by race/ethnicity and gender (age and citizenship status matter as well). Jobs, like social protection programmes, are segmented. Historically, women and non-whites were formally and informally excluded from most jobs that pay family wages (including provision of employer-based benefits such as health insurance, paid time off and retirement plans) and provide opportunities for advancement (Gordon et al. 1982; Kessler-Harris 2007). The legacy of black slavery and servitude has helped shape the norms for non-white workers, evident by the ways in which people of colour, especially women, are highly over-represented in low-wage service work (Glenn 1992). The civil rights and women's movements' exposure of exclusionary practices helped fuel equal opportunity policies. While there has been some progress, high levels of racial economic inequality – as measured in unemployment rates, wages, family income and wealth – still persist. Further, gendered care norms shape women's employment choices and wages, with mothers working fewer hours than other women as well as facing a wage penalty (Budig and England 2001).

The segmented employment regime reinforces the tiered social welfare policy regime, and together these 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 and

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 with 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 own 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 labour market and the social protection system in the United States have developed in decentralized ways with a strong reliance on private market mechanisms and state-level authority in ways that privilege certain workers, with access to jobs and protections built on racial and gender hierarchies. Despite the removal of many formal barriers, institutional structures that reinforce gender and racial hierarchies persist, especially in labour markets and in fragmented and decentralized means-tested programmes. As discussed in the next section, this is also true of access to health care services.

4.

HEALTH-CARE COVERAGE AND ACCESS

Health insurance coverage maps directly onto the US social protection tiers. There is mandatory employment-based coverage for persons 65 and older and some disabled workers; employment-based voluntary programmes are available for many but not all workers and their families; and there are government means-tested programmes for most uncovered children, some poor parents, some very poor non-parent adults and poor disabled adults. Still this has left many uncovered. Those individuals can purchase (at full cost) private individual coverage or remain without any insurance, paying for any health-care services out-of-pocket or relying on charity care. Everyone, except for eligible veterans using the federal Veteran's Administration health services,⁹ relies on private health-care providers for their care. This heavy reliance on private health insurers, and without a commitment to moving toward universal coverage until the ACA, has created a largely unregulated and very uneven system of health-care coverage and delivery. One implication is that health services are costly and prices vary widely, even for the same procedures (Rosenthal 2013). Another is that many people, even those with insurance, cannot afford to receive the care they need.

As with most aspects of everyday life, especially those concerning the delivery of care, women's relationships 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) and are more likely to have health insurance than are men; women have greater needs during child-bearing years and have particular reproductive health needs; and, as primary caregivers, women interface with health-care providers on behalf of others. 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, especially low-income and uninsured women, report

going without or delaying needed care and filling prescription due to costs (*ibid.*).

Females are slightly less likely to lack health insurance than males, with 14.1 per cent of all females uninsured compared to 16.7 per cent of all males.¹⁰ However, both the level of the per cent that are uninsured and the gender insurance gap varies by age, which is a key determinant of access to government health insurance. Figure 4-1 depicts the percentage of males and females uninsured by age.¹¹ Of those 65 and older, only 1.6 per cent of women and 1.4 per cent

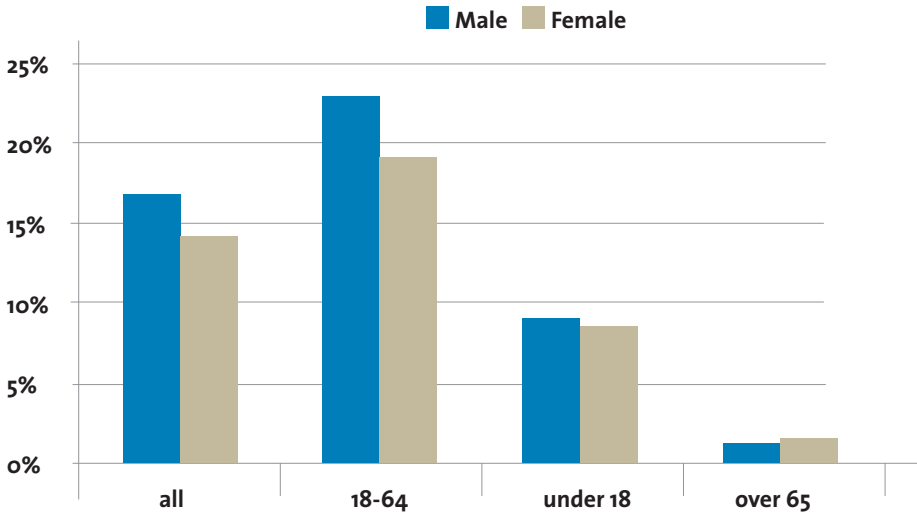
⁹ Any person that has served in active military service and was not dishonourably discharged or released is eligible.

¹⁰ Unless otherwise noted, all data used in this section and the next were derived by the authors using 2013 ASEC Supplement to the Current Population Survey covering information from 2012, using the Uniform Extracts prepared by the Center for Economic and Policy Research 2014.

¹¹ 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.

FIGURE 4-1

Percentage uninsured by gender and age, 2012



Source: Authors' calculation using 2013 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

of men lack health insurance. These very low levels of non-coverage reflect the universality of Medicare coverage. And while it is not universal, nine out of ten children have health insurance (8.7 per cent of females and 9.0 of males under age 18 lack insurance). The state CHIP programme helps ensure that children, regardless of gender, who are without (employer-based or privately purchased) coverage from their parents get government-supported insurance. But the adult population aged 18–64, the group most likely to be employed and least likely to be eligible for pre-ACA government-supported coverage, faces higher rates of non-coverage, with over one out of every five (21.0 per cent) having no health insurance in 2012. It is in this age group that the gender gap and the uneven implications of the social protection system are most apparent. There were 21.8 million men (22.9 per cent) aged 18–64 without insurance compared to 18.9 million women (19.2 per cent).

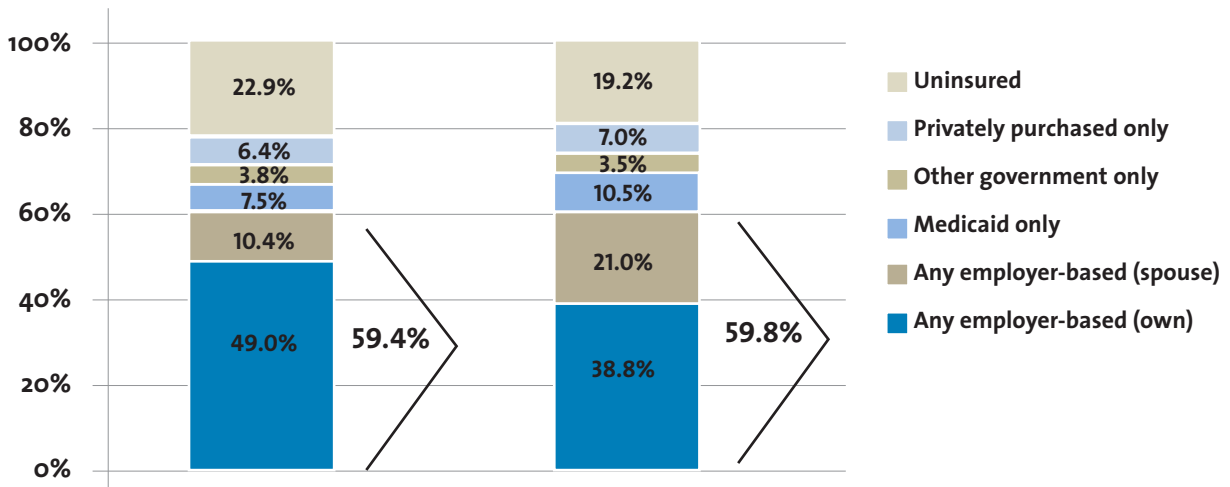
Figure 4-2 provides a closer look at the type of insurance women and men aged 18–64 have and reveals that almost the entire gap is explained by access to Medicaid. Women have higher poverty rates than men and, as discussed in the previous section, poor

mothers (especially single mothers) are more likely to have access to means-tested programmes by design. Similarly, while the percentage of men and women with employer-based insurance is almost identical (59.4 per cent versus 59.8 per cent), 20.1 per cent of all women receive that coverage through their spouses versus 10.4 per cent of men. Because women are more likely than men to be covered as a dependent, they are at greater risk of losing coverage if they are widowed or divorced, their spouse loses a job, or their spouse's employer drops family coverage or increases premiums and out-of-pocket costs to unaffordable levels.

There is a large income gap in coverage. Of all those who were uninsured in 2012, 28.7 per cent were officially poor (their family income was below the income threshold set by the government), compared to 15.1 per cent of the population overall who were poor. The income thresholds that determine poverty levels are based on family size and composition. For a family of three with one adult and two children, the annual poverty income threshold was \$18,498. An additional 30.2 per cent of the uninsured had income above the poverty threshold by less than 200 per cent of that level. Figure 4-3 depicts the percentage of all males

FIGURE 4-2

Type of insurance for males and females ages 18-64, 2012



Source: Authors' calculation using 2013 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

and females as well as those aged 18–64 that are uninsured by the income bracket as measured by the percentage of the poverty income threshold for all males and females and for those aged 18–64. Almost half of all poor men aged 18–64 lack insurance while just under 40 per cent of females do.

Because social protection policies and labour market mechanisms are shaped not only by gender but also by family structure (including marital status and presence of children), race/ethnicity, citizen status and age, we also expect to see variation in lack of health insurance coverage across these groups. Table 4-1 includes percentage and number uninsured and distribution of the entire and uninsured populations of women aged 18–64 by race/ethnicity, citizenship status and age group. Table 4-2 depicts the percentage and number uninsured and the distribution of the entire and uninsured populations of those aged 18–64 by gender and family status.

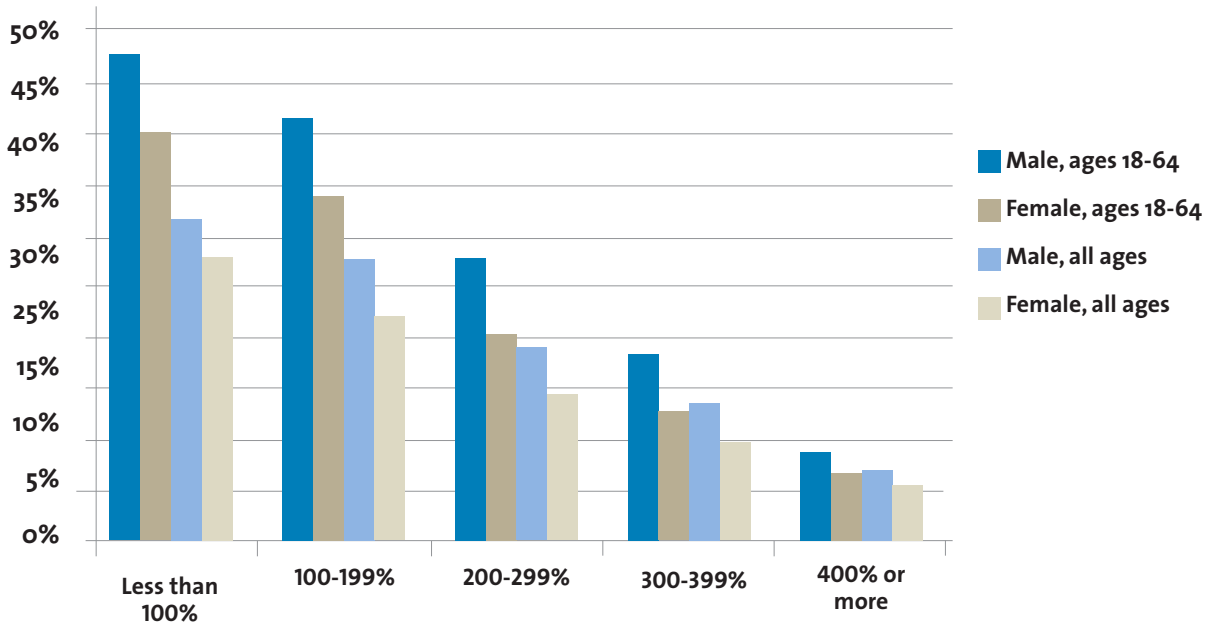
Marital status is a strong predictor of who will be uninsured. Single women and men, with and without children, are almost twice as likely to be uninsured than their married counterparts. Among women,

single mothers have the highest percentage who are uninsured at 28.1 per cent, followed by 23.2 per cent of single women with no children under the age of 18. Almost one third of all single men (with or without children) lack insurance. As expected, white women are much more likely to have insurance than are other women, as are those born in the United States and older women. Women who are not US citizens face the highest level of being uninsured of any group of women explored here.

Regression analysis helps sort out confounding factors. Using a probability regression for adults aged 18–64 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 age (and age squared), education level, race/ethnicity, class of employment and citizenship status, single mothers were significantly more likely to be uninsured than married women and men (with and without children) but less likely than single fathers and single women and men without children. Among the likelihood of having employment-based insurance, single mothers were significantly less likely of all family

FIGURE 4-3

Percentage males and females uninsured by percentage of poverty income thresholds and age group, 2012



Source: Authors' calculation using 2013 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

statuses to have this type of insurance, adjusting for the other factors (listed above) that influence insurance coverage.

Because the methods used to collect data on health insurance status substantially changed in the late 1980s and again in the mid and late 1990s, it is not possible to show long-term trends in coverage. Instead, we present data from 1999 to 2012 for women and men aged 18–65 (Figure 4-4). Employer-sponsored insurance and directly purchased coverage for women and men 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 it is almost identical. Directly purchased insurance coverage has risen only slightly (less than 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 and rising for both. As in Figure 4-2, Medicaid coverage accounts for most of the difference in the gender insurance gap over the entire period.

In addition to women's and men's lack of access to insurance, health insurance companies and state and federal policies have also served to deny access to health-care services to women (and men) with health insurance. Prior to the ACA, insurance companies were allowed to consider gender in setting premium rates in the private individual insurance market. By 2009, 95 per cent of the best-selling plans in the individual market practiced gender rating (National Women's Law Center 2009). This had several gender implications. For example, 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, such as maternity care. In 2009, only 13 per cent of health plans provided maternity coverage to 30-year-old women. Insurance

TABLE 4-1:
Distribution of women aged 18–64 by insurance status and race/ethnicity, citizenship status and age group, 2012

	Per cent uninsured	Number uninsured (in 1000s)	Per cent of total	Per cent of uninsured
RACE/ETHNICITY				
White	14.0%	8,605	62.5%	45.5%
Black	23.0%	3,077	13.6%	16.3%
Hispanic	36.1%	5,732	16.1%	30.3%
Asian	18.5%	1,178	6.5%	6.2%
Other	25.3%	326	1.3%	1.7%
NATIVITY AND CITIZENSHIP STATUS				
Born in the United States	16.2%	13,334	83.4%	70.5%
Foreign born, citizen	22.5%	1,660	7.5%	8.8%
Foreign born, not a citizen	43.6%	3,924	9.1%	20.7%
AGE GROUP				
18–24	23.9%	3,555	15.1%	18.8%
25–34	23.6%	4,952	21.3%	26.2%
35–44	18.8%	3,809	20.6%	20.1%
45–54	17.0%	3,775	22.5%	20.0%
55–65	14.0%	2,827	20.5%	14.9%
TOTAL	19.2%	18,918	100.0%	100.0%

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

TABLE 4-2:
Distribution of uninsured men and women aged 18–64 by family status, 2012

Family status	Per cent uninsured	Number uninsured (in 1000s)	Per cent of total	Per cent of uninsured
Single female, with children under 18	28.1%	3,031	5.6%	7.4%
Single male, with children under 18	32.2%	933	1.5% d	2.3%
Married female, with children under 18	16.0%	4,183	13.5%	10.3%
Married male, with children under 18	15.7%	4,004	13.2%	9.8%
Single female, no children	23.2%	8,537	19.0%	21.0%
Single male, no children	31.4%	13,931	22.9%	34.2%
Married female, no children	12.8%	3,166	12.8%	7.8%
Married male, no children	13.2%	2,939	11.5%	7.2%
Total	21.0%	40,726	100.0%	100.0%

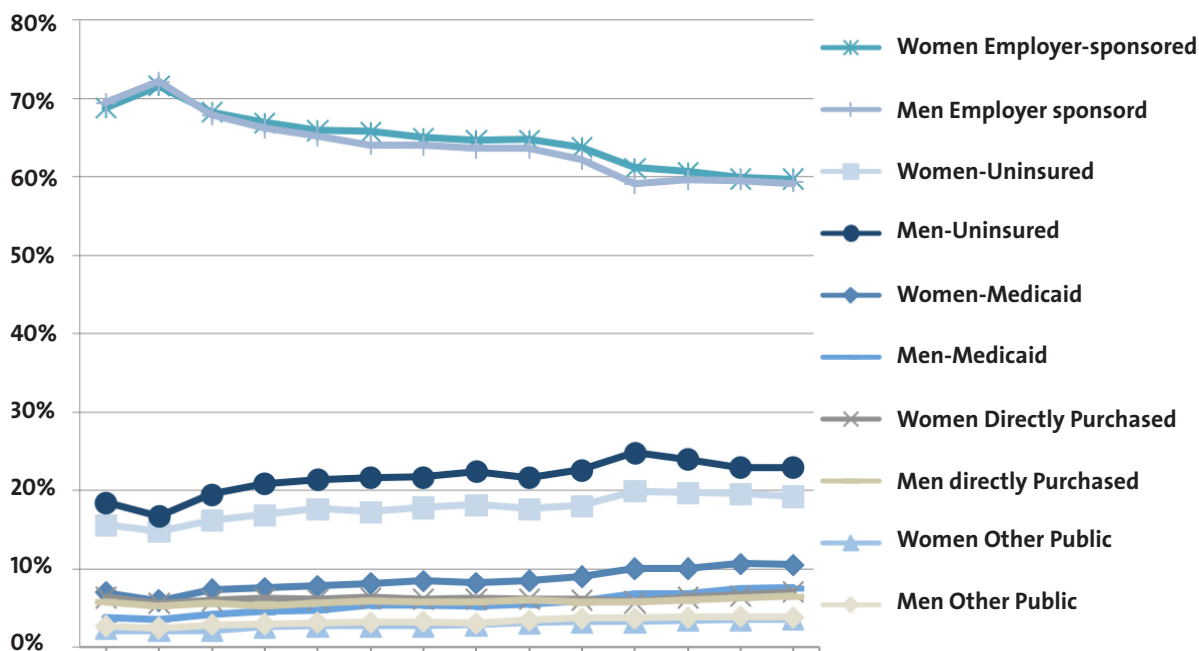
Source: Authors' analysis of the 2012 ASEC Supplement to the Current Population Survey.

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.

Federal funding for abortions has been illegal since 1977, except when the pregnancy is a result of rape or incest or woman’s life is in danger. 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).

FIGURE 4-4
Percentage of women and men aged 18-64 by type of insurance, 1999-2012



Source: Authors’ calculation using 2012 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.
 Note: Percentage for employer-sponsored insurance may include individuals with multiple insurance coverage.

5.

POTENTIAL GENDERED IMPACTS OF THE ACA

Within the context of the gendered and racialized US social protection model and labour market, this section outlines the ways in which the ACA both improves health-care provision for women (and men) but also reproduces gender (and racial) inequality within three key goals of the legislation: (a) expanding access, (b) insurance market reforms and (c) reducing costs while increasing quality.

a) Expanding access

Because the key provisions for expanding access were first implemented in 2014, there are no data yet available on the impact of those changes. However, the state of Massachusetts implemented a very similar version of the ACA in 2006, and health insurance coverage increased from 90 per cent of the population in that year to 97 per cent in 2011 (Commonwealth of Massachusetts 2013). These are promising results, but notably the state paid for expanding coverage to low-income adults, something not assured currently by the ACA. Recent opinion surveys asking about coverage as well as enrolment numbers in exchanges and Medicaid indicate improvements in coverage. There are three mechanisms for expanding access: employer responsibility, government programme expansions and individual mandates.

Employer responsibility

The majority of the population (54.9 per cent in 2012) relies on employment-based insurance, sometimes in conjunction with other forms of insurance (DeNavas-Walt et al. 2013: 8). Yet over 30 per cent of employees are not covered by employment-based insurance (31.9 per cent of employed men and 29.6 per cent of employed women), and 18.3 per cent of those employed report no form of health insurance (16.1 per cent of employed women and 20.3 per cent

of employed men) (authors' calculations using 2013 Current Population Survey).

The employer responsibility 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.¹² 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.¹³ In addition, at least one large firm (UPS), in anticipation of the ACA and potential mandate costs, has already announced it is 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

¹² See Kaiser Family Foundation 2103b for a flow chart on employer penalty rules.

¹³ Using simulation models, Blumberg et al. 2103 estimate that it will increase coverage by 0.1 per cent while Eibner et al. 2010 find that firms with more than 50 employees will increase coverage by 3.5 per cent.

disproportionately affect women. The implementation of this provision has been postponed until 2015.

Small employers are the least likely to cover employees. Under the ACA they are offered tax incentives to do so and can join exchanges to reduce costs. 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 65 per cent of uninsured men in firms with fewer than 100 employees compared to 55 per cent of uninsured women (authors' calculations using 2013 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 make group insurance coverage more affordable. If this indeed happens, the impact on women's coverage is likely to be positive; however, compared to the individual mandate and the Medicaid expansion, it will be small.

The employer provision will most likely increase coverage, but it will not address the variability of coverage. Higher-paid workers are likely to have better coverage. Workers in firms that employ large percentages of low-wage workers also pay a higher percentage of their premium than other workers on average. They also have higher average deductibles and their employers are the least likely to provide retiree health benefits (Kaiser Family Foundation and Health Research and Educational Trust 2013). Women are more likely to be low-wage workers (defined as two thirds of the state median wage) than are men.

Government programme expansions

In 2012, nearly a third of all persons were on some kind of government plan (mainly seniors, children, low-income individuals and veterans) (DeNavas-Walt et al. 2013: 8). The Medicaid expansion provisions of the ACA hold significant promise for expanding coverage to uninsured women (and men). To be eligible for the Medicaid expansion, a person has to have family income at or below 138 per cent of the federal poverty

income threshold and be a citizen or a legal non-citizen who has resided in the United States for five or more years. Of the 22.5 million uninsured women in the country in 2012, 9.8 million – 45 per cent of all uninsured women – would potentially be eligible. Men will also benefit, but probably not as much as women, in large part because their family income is higher than women's and will less often meet the income threshold. There are 9.2 million uninsured men who are eligible for Medicaid expansion, accounting for 37.7 per cent of the 24.5 million uninsured men. And while this would reduce the percentage of uninsured men, ironically this provision could serve to widen the gender gap in insurance coverage.

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 enrol children, the streamlined application process and the fact that plans sold in the exchanges must contract with navigators to conduct outreach and enrolment assistance (Holahan et al. 2012). However, because of the 2012 Supreme Court ruling, which makes the Medicaid expansion separable from the current Medicaid programme and sharply reduces the penalties for not opting to expand, many states indicated they would not adopt the expansion scheduled to begin on 1 January 2014. As of August 2014, 24 states have made a decision not to move forward (Kaiser Family Foundation 2014b).¹⁴

The ability to opt-out will have a profound effect on adult, non-elder women's coverage. Of all women aged 18–64, 44.4 per cent live in the 24 'opt-out' states. However, 50.9 per cent of all uninsured women and 53.6 per cent (4.4 million) of ACA Medicaid-eligible uninsured women aged 18–64 live in those states. Not extending Medicaid as provided under ACA will preclude coverage to 23 per cent of all uninsured women aged 18–64. Of men, 43.9 per cent aged 18–64 live in

¹⁴ The states not moving forward at this point are: Alaska, Alabama, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, North Carolina, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin and Wyoming (Kaiser Family Foundation 2014b).

those states not extending Medicaid, but these states are home to 48.6 per cent of uninsured men and 48.5 per cent (3.7 million) of ACA Medicaid-eligible men aged 18–64. However, these impacts are not spread evenly among either women or men. Table 5-1 details the percentage of total uninsured and percentage of the newly Medicaid-eligible uninsured for women and men aged 18–64 that reside in the 24 ‘opt-out’ states by various characteristics of the uninsured. It also includes the percentage of Medicaid-eligible uninsured in opt-out states as a percentage of all the uninsured. Table 5-2 provides the same information for women and men by family type. Across the two tables, the uninsured subpopulations that are highly over-represented in the states opting out of the Medicaid extension are black men and women and single women with children. About two thirds of uninsured and Medicaid-eligible uninsured black women aged 18–64 live in the opt-out states. This means that one third of all uninsured black women in that age bracket who would have otherwise be eligible for government health-care coverage will now not be. This outcome is consistent with the ways in which state-administered means-tested programmes have excluded black women historically. Single mothers also face over-representation in opt-out states and will therefore be disproportionately uninsured as the ACA proceeds. The subpopulations that are under-represented in the opt-out states are foreign-born citizens and Asians.

While Medicaid-eligible uninsured women and men (except non-legal residents) that live in opt-out states can purchase private insurance through exchanges, without legislative changes those with income 100 per cent below the federal poverty income threshold (also referred to as the Federal Poverty Level (FPL)) will not be eligible for any federal credits or subsidies. Given the high cost of insurance, these adults are likely to be exempt for financial reasons from the individual mandate (discussed below), leaving a substantial group of economically vulnerable women (and men) still uncovered.

The changes to Medicare coverage are slight, but they will disproportionately positively affect women. Among Medicare 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 2013c). Most of the conditions require prescription drugs, and therefore closing the ‘donut hole’ that currently exists for Medicare-related drug prescriptions will disproportionately benefit women. These same women should also benefit from new efforts to coordinate care.

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 programmes. These plans must include essential benefits, including critical preventative services for women. Anyone with incomes between 100 and 400 per cent of the federal poverty income threshold can receive a subsidy or tax credit for the cost of the insurance. Of the 18.9 million uninsured women aged 18–65, 10.5 million have incomes in the range that makes them eligible for federal assistance with paying for insurance (13.1 million of the 21.8 million uninsured men are also in that income range).

This portion of the ACA was implemented in 2014, with people signing up for coverage through exchanges in Fall 2013. States could create their own exchanges and the accompanying mechanisms for people to sign up, they could set up partnership exchanges or they could defer to the federal government to set up the exchanges that enrol people into state-based plans. As this went into effect, 17 states set up their own exchanges, 7 created partnership exchanges and 27 deferred to the federal government (Kaiser Family Foundation 2014c). Despite initial computer glitches with the federal exchange website as well as in some states, just over 8 million people enrolled in the first six months of the enrolment period, with 54 per cent of those female and 28 per cent between the ages of 18 and 34 (US Department of Health and Human Services, Office of the ASPE 2014). Opponents of the ACA have filed a lawsuit arguing that the federal subsidies under the individual mandate do not hold in states that have used the federal exchanges (generally the states led by Republican legislatures and governors). Two federal appeals court provided divided

TABLE 5-1:

Potential impacts of Medicaid ‘opt-out’ decisions on the uninsured (in 2012) for women and men aged 18–64, by various characteristics

	Per cent of total female uninsured in opt-out states	Per cent of all female uninsured and Medicaid-eligible in opt-out states	Uninsured female and Medicaid-eligible in opt-out states as a percentage of all female uninsured	Per cent of total male uninsured in opt-out states	Per cent of all male uninsured and Medicaid-eligible in opt-out states	Uninsured male and Medicaid-eligible in opt-out states as a per cent of all female uninsured
TOTAL	50.9%	53.3%	23.2%	48.6%	48.5%	17.0%
RACE/ETHNICITY						
White	50.7%	51.8%	19.7%	49.3%	47.8%	14.8%
Black	64.8%	66.6%	34.6%	60.7%	60.2%	26.5%
Hispanic	48.0%	51.0%	25.1%	44.9%	45.2%	17.3%
Asian	29.3%	30.1%	8.3%	30.7%	26.5%	5.9%
Other	54.6%	52.9%	29.5%	52.7%	52.6%	23.5%
Nativity						
Born in the US	53.9%	56.5%	24.3%	50.9%	50.9%	17.5%
Foreign born, citizen	40.9%	45.7%	16.7%	40.7%	43.7%	13.7%
Foreign born, not a citizen	44.9%	47.1%	22.2%	44.1%	42.9%	16.2%
Age group						
18–24	50.0%	52.2%	23.7%	49.5%	49.8%	19.2%
25–34	51.4%	54.8%	25.4%	48.0%	48.4%	15.7%
35–44	52.9%	54.2%	25.7%	48.1%	48.7%	18.5%
45–54	50.6%	53.7%	20.2%	49.0%	47.3%	16.2%
55–65	49.0%	52.1%	19.3%	49.1%	47.9%	15.1%
Education level						
Less than HS	51.6%	53.9%	32.3%	52.1%	50.7%	23.5%
High school	54.2%	56.0%	25.8%	48.8%	48.2%	17.4%
Some college	49.8%	51.6%	20.0%	47.8%	48.4%	14.8%
College	45.3%	50.4%	13.7%	45.1%	42.5%	9.3%
Advanced	41.8%	42.0%	9.8%	41.2%	42.7%	8.1%

decisions, so that the fate of that aspect of the ACA, designed to create affordability, remains contested as of August 2014.

b) Insurance market reforms

Important aspects of the ACA are insurance market reforms, which may particularly assist the nearly 10 per cent of the population that in 2012 purchased

insurance directly from the private market (DeNavas-Walt et al. 2013: 8).

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 aged 19–25 (US Department of Health and Human Services 2012). Women, in particular, will benefit from several

TABLE 5-2:

Potential impacts of Medicaid ‘opt-out’ decisions on the uninsured (in 2012) for adults aged 18–64, by gender and family type

	Per cent of total uninsured in opt-out states	Per cent of all uninsured and Medicaid-eligible in opt-out states	Uninsured Medicaid-eligible in opt-out states as a percentage of all uninsured
All adults	49.7%	51.1%	19.9%
Single female, with children under 18	60.7%	61.5%	39.7%
Single male, with children under 18	47.8%	46.3%	22.8%
Married female, with children under 18	53.5%	54.6%	22.6%
Married male, with children under 18	53.1%	53.5%	21.9%
Single female, no children	46.7%	49.7%	21.8%
Single male, no children	46.9%	46.8%	16.4%
Married female, no children	49.3%	50.2%	12.1%
Married male, no children	51.2%	50.3%	11.2%

aspects of insurance market reforms because prior to the ACA, as previously noted, they 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. 2010). The law eliminates the gender rating that permitted the individual insurance market in 42 states 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, which for some included pregnancy.¹⁵ Estimates of the share of women aged 19–64 with a pre-existing conditions in 2009 ranges from 21 to 72 per cent, higher than the estimated range for men of 18 to 59 per cent (US General Accounting Office 2012: Figure 4-1).

The ACA mandates a set of comprehensive services for women that address needs across the life span

¹⁵ 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 most commonly reported being hypertension followed by mental health disorders, diabetes and asthma (US Government Accounting Office 2012).

(except abortions, see below) and that insurance plans must provide and for which they cannot charge co-payments, coinsurances or deductibles. 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; sexually transmitted infections (STIs) counselling; HIV screening and counselling; contraception and contraceptive counselling; breastfeeding support, supplies and counselling; and interpersonal and domestic violence screening and counselling (HHS.gov/HealthCare 2011). Average female out-of-pocket expenses were \$748 in 2010 compared to a 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.

Contraception and abortion services remain highly 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, HRSA 2013). Religious organizations were granted an exemption in paying for insurance coverage for contraception drugs and devices and abortion services. In another legal challenge to the ACA, a privately held corporation (Hobby Lobby) successfully argued before the Supreme Court that, because of the owners' religious beliefs, they should not be mandated to provide emergency contraception coverage (arguing that these drugs and devices end life after conception).

As previously noted, federal funding for abortions is illegal (under the 1976 Hyde Amendment) except when the pregnancy is a result of rape or incest or woman's life is in danger. Therefore 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, states have to estimate the actuarial value of abortion coverage (valued as at least \$1 per enrollee per month), and plans that receive federal subsidies would have to collect two premium payments from all enrollees (women and men 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 limit access. These provisions do not apply to employer-sponsored insurance, unless they are offered through the exchanges.

c) Reducing cost, improving delivery of care

It is expected that health-care systems reform will address rising costs and the low quality of care, benefiting both women and men. The ACA makes the process easier for consumers by creating one site where they can apply and determine eligibility for government and private market plans. The funds dedicated to workforce programmes 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 on addressing the potential nursing shortage (a traditional female occupation). Although many women, especially women of colour and migrant women, work in the lower-wage occupations within the health-care systems, new pipeline programmes may allow women more opportunities for career growth. Cultural competency in health-care delivery systems is increasingly critical, especially with the growth in non-white new eligible enrollees. Improved data collection techniques are even more important as the country becomes more diverse, because women from different cultural and ethnic backgrounds face particular health ailments that are often masked when the data are collected just by sex and not disaggregated by race/ethnicity or disability. Investments in community health centres will help low-income women and their families receive quality care.

Left behind: recent immigrants and non-citizens

There are planned and unexpected exemptions to the ACA. In addition to the potentially large number of poor and low-income uninsured women eligible for Medicaid expansion but who live in states that have opted out, there is one other large group of women (and men) explicitly excluded from coverage under the ACA – noncitizens. Noncitizens are more likely to be uninsured than citizens. In 2009, 51 per cent of noncitizen adults and 38 per cent of noncitizen children were uninsured, compared to 18 per cent of citizen adults and 8 per cent of citizen children (US Department of Health and Human Services, Office of the ASPE 2012a). Since 1996, legal immigrants have been barred from Medicaid and CHIP during their first five years in the country, and this provision still holds unless states opt out. 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 centres or safety-net hospitals, and if they are low-income can qualify for Emergency Medicaid. Citizen children or legal permanent resident (LPR) children

of undocumented parents follow the same rules as adult citizens and LPRs (National Immigration Law Center 2013).

Naturalized immigrants can access the benefits of the ACA much like native-born citizens. LPRs have limited federal coverage and protections but 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. 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 programmes such as Supplemental Nutrition Assistance Program (SNAP), TANF, Medicaid or CHIP (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 and 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 per cent) of the undocumented population, 34 per cent and 13 per cent respectively (ibid.). 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 per cent), construction (14 per cent) and food prep and maintenance work (roughly 8 per cent each) (US Department of Labor, Bureau of Labor Statistics 2010). Immigrant women were more likely to be employed in service occupations (33 per cent) such as domestic work, cleaning, maintenance and health-care support, and 24 per cent were in sales occupations. Many

of 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 well-being.

For immigrant women, in particular undocumented women, the lack of health insurance may lead to effects on children (Perreira and Ornelas 2011). Although migrant children may start out healthier than native-born children, over time good health declines (Harris, 2000). Compared to other women, undocumented immigrant women have less access to preventive services, start prenatal care later and have fewer prenatal visits, and their use of the prenatal care varies with the availability of publicly funded prenatal programmes (ACOG 2009). Undocumented pregnant migrant women and children may have access to Medicaid or CHIP 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 ASPE 2012b).

The ACA outlines specific verification requirements that include providing a social security number and immigration status when applying for any benefit – Medicaid, CHIP, premium tax credits or private health insurance in the exchanges. It also assures that immigration status is intended to be used solely 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 limit legal immigrant participation and can only be exacerbated by the law.

In addition to immigrants, those with extreme financial hardship, people with religious objections, Native Americans and incarcerated individuals are exempt from the individual mandate. The system makes it difficult to achieve universal coverage and reach human rights standards and norms.

6.

THE ACA AND THE MOVE TOWARDS HUMAN RIGHTS NORMS

In conclusion, the ACA moves the United States closer to universal health coverage, aligning it more closely with other industrialized nations, but fails to fulfil human rights norms. It expands coverage by requiring more employer-based insurance, mandating individuals to purchase insurance and reforming aspects of the insurance market. The expansion rests on the complicated and uncoordinated system that was already in place. The labour market mechanisms and the state-level provision of social welfare limits access for many groups (e.g., low-income women of colour in the Southern states) in addition to those in the planned exemptions.

US political discourse tends to shy away from discussions of human rights and the country has not ratified the international conventions that guarantee health as a human right. In response to a direct question about health care during one of the 2008 presidential debates, Democratic candidate Barack Obama declared health care to be a right.¹⁶ 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.¹⁷

Although the ACA is a move in the right direction, it lacks key aspects to guaranteeing health as a human right. We use the United Nations Office of the High Commission for Human Rights eight key aspects underlying the right to health as our yardstick: (1) health-care facilities, goods and services must be available in sufficient quantity; (2) health services must

be physically and financially accessible; (3) provision should be medically and culturally acceptable (including gender sensitive); (4) services should be of good quality; (5) services should be non-discriminatory; (5) the beneficiaries should participate in the design and implementation of services; (7) there should be accountability for meeting these obligations; and (8) the underlying capabilities (such as adequate housing and food) that assure the ability to secure the right to health should also be present (United Nations Human Rights n.d.).

The ACA establishes the Community-based Collaborative Care Network Program to support consortiums of health-care providers to coordinate and integrate health-care services for low-income uninsured and under-insured populations. It provides additional funding to community-health clinics, which will increase the availability of services. It also aims to improve the quality and equitable distribution of services by mandating a comprehensive set of services, including reproductive and maternity/infant care that were traditionally not covered by many insurance plans or cost more to include them. It reforms the health insurance market by eliminating the use

¹⁶ During Presidential debates in 2008, in response to a question asking if health care in America is a privilege, right or responsibility, then candidate Obama replied, "Well, I think it should be a right for every American" (LA Times 2008).

¹⁷ This is the approach President Obama presents in his 2010 State of the Union Address (Whitehouse.gov 2010).

of a gender rating that charged more for insurance or provided inadequate coverage. The law allocates funding to train a diverse workforce and increase cultural competency training and also requires enhanced data collection and reporting of data on race, ethnicity, sex, primary language, disability status and urban/rural populations. In addition, the law creates several organizations and councils to determine the effectiveness of medical treatments, evaluate public health and wellness programmes and develop a National Quality Improvement Strategy that prioritizes the delivery of health care and improvement of health outcomes. These investments increase the availability and accessibility of health-care systems, improve the quality of services received and promote an understanding of the underlying determinants of poor health or lack of access to health care.

However, the planned exemptions to the individual mandate will still leave millions of people uninsured, including those with extreme financial hardship, people with religious objections, Native Americans, 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. It does not require all firms to provide employer-sponsored insurance as small firms (fewer than 50 employees) are exempt, it allows other small firms (up to 100 employees) to use the exchanges, and it 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. The ability of states to opt out of Medicaid extension

severely hampers the goal of near universal coverage. Although it makes reforms to increase participation in the health-care insurance market, it intentionally discriminates against certain populations by limiting or barring access to health care.

There is little in the law about the participation of the public in developing the health-care interventions, although at local levels hospitals and community-based clinics often have constituent advisory groups. It contains few accountability mechanisms, in terms of violations to the right to health, but it does develop a database to capture and share data across federal and state programmes to monitor waste, fraud and abuse, increase penalties for submitting false claims, strengthen standards for community mental health centres and increase funding for anti-fraud activities. These mechanisms, however, are aimed at cost containment and not necessarily at guaranteeing a right to health. Finally, the ACA does not address the sets of underlying determinants of good health, such as adequate housing, food or healthy work conditions. In fact, as discussed, the ACA is a patchwork of market and public reforms aimed at addressing the complex market-oriented system and will likely further embed the gender, racial/ethnic and income biases that are often ingrained in US social policies.

While the passage of the ACA was a historic moment in the country's history, the over-dependence on market-based mechanisms, the historic and contemporary limits to social welfare by the most vulnerable (based on income, racial/ethnic and gender) and important lack of overhaul of the insurance markets will continue to leave millions of people uninsured.

BOX 6-1

Key provisions of 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 health-care delivery system.

EXPANDING COVERAGE

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 per cent of all establishments and 28.1 per cent 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 also purchase coverage in these exchanges.

Expansion of public programmes. The ACA provides states with enormous financial incentives¹⁸ 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 per cent of the federal poverty line (FPL).¹⁹ The FPL was

\$19,530 for a family of three in 2013.²⁰ Medicaid is the government programme 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.

The ACA also expands Medicare coverage to key preventive services with no additional charge, reduces and eventually eliminates the coverage gap ('donut hole'²¹) for prescription drugs and promotes initiatives that improve care through coordinating all levels of care. Medicare is the government programme that provides health insurance coverage for persons over age 65 and those with some disabilities.

Individual mandate. Most US citizens and legal permanent residents must have health insurance by 2014 or face a tax penalty. Insurance coverage can be purchased through state-based exchanges, which organize the competitive market for health insurance in each state.

To help promote affordability, federal government tax credits for the cost of the premium are available for those with incomes between 100 and 400 per cent of the FPL. Cost-sharing subsidies for deductibles, co-payments and coinsurance are also available to eligible individuals/families, typically those with income between 100 and 250 per cent of the FPL. Individuals exempted from the

¹⁸ The federal government will pay 100 per cent of the cost of the Medicaid expansion from 2014 through 2016. This will be reduced to 90 per cent by 2020.

¹⁹ The legislation calls for expanding coverage to those with family income no more than 133 per cent of the FPL, but allows for a 5 per cent income disregard, effectively making the family income cut-off 138 per cent of the FPL.

²⁰ The FPL varies by family size and composition. The levels were determined in the 1960s and are adjusted every year for inflation.

²¹ Medicaid (Plan D) is a prescription drug plan in which beneficiaries have to pay 25 per cent 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 per cent of the costs. When above the gap limit, catastrophic coverage is automatically provided, assuring small coinsurance or co-payments for covered drugs for the rest of the year.

individual mandate include those with religious objections, Native Americans, those without coverage for less than three months, undocumented migrants, incarcerated individuals and those with financial or other hardships.

CONSUMER PROTECTIONS

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 such as maternity care. Depending on the type of insurance, reproductive health services such as birth control pills required co-payments. 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 (that now includes maternity, newborn care, paediatric care, behavioural 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.²² 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.

²² For a list of mandatory essential health benefits (Healthcare.gov 2013) see <https://www.healthcare.gov/glossary/essential-health-benefits/>.

REDUCING COST, IMPROVING DELIVERY OF CARE

The multi-levelled, decentralized delivery system of health care 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 programme accomplished through modernizing financing systems, reforming provider payments and promoting accountable care practices that prevent medical relapses.²³

The ACA provides funding for workforce development programmes intended to ensure a diverse cadre of health professionals; requires enhanced collection and reporting of data on race, ethnicity, sex, primary language and disability status; and require the Secretary of Health and Human Services to analyse the data to monitor trends in disparities. There will be additional monies for cultural competency investments in health-care systems, as well as for community health centres and school-based health clinics.

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

²³ 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 per cent, prohibits federal payments to states for Medicaid services related to health-care acquired conditions, eliminates the Medicare Improvement Fund and reduces the Medicare Part D premium subsidy for those with higher incomes (Kaiser Family Foundation 2013a).

APPENDIX:

US GOVERNMENT HEALTH PROGRAMMES

Medicaid/CHIP (before ACA expansion)

Medicaid is a means-tested health insurance programme enacted in 1965 directed toward poor children, poor parents, other caretaker relatives, pregnant women, seniors and disabled adults without other types of health-care coverage. As an entitlement programme, anyone that meets the eligibility requirements is entitled to receive the services. The Children's Health Insurance Program (CHIP), established in 1997, 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 2012, Medicaid provided health coverage for 46.9 million people, 15.2 per cent of the population.

Financing: The federal and state governments fund Medicaid/CHIP jointly, typically using general revenues. The federal government pays a percentage of programme expenditures that varies by state, ranging from 50 per cent in wealthier states up to about 75 per cent in poorer states, with an average of 57 per cent. As an entitlement, funding levels fluctuate from year to year, with increased usage during recessions. In 2012, total federal and state Medicaid spending was \$422 billion, representing 2.6 per cent of GDP and serving 55.9 million people. States have the option to charge premiums and to establish cost-sharing mechanisms such as co-payments, coinsurance, deductibles and other similar charges. However, certain groups, such as pregnant women and children, are exempt from most out-of-pocket costs and co-payments. As an incentive for states to expand their coverage programmes for children, there is an enhanced federal matching rate for CHIP that is generally about 15 percentage points higher than the Medicaid rate, averaging 71 per cent nationally.

Service coverage: States administer Medicaid/CHIP programmes. 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 programmes 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 (such as 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 an income below 133 per cent of the FPL; most seniors and disabled people who already receive cash benefits from the federal Supplemental Security Income programme; and children aged 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 programme, but because these eligibility levels are so low and vary considerably, there is enormous variation across states. Over half the states have income eligibility for jobless parents at or below 50 per cent 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 per cent of the FPL, with the option of receiving federal funding to cover children up to 300 per cent. 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 non-emergency 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 and are poorer than men, are dependent caretakers and are eligible when pregnant. In 2012 11.7 per cent of women 18 and older were covered by Medicaid, compared to 8.7 per cent 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) have opted to expand Medicaid eligibility to cover the costs of family planning services (sometimes including abortion) for low-income women, and all states have established Medicaid programmes 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 because of women's longer life spans, there are more women than men over the age of 64 receiving Medicaid coverage.

Medicare

Medicare is an entitlement programme for people aged 65 and over, people younger than 65 years old with certain disabilities and anyone with end-stage renal disease. In 2012 Medicare covered 49.7 million people, or 15.9 per cent of the population. It has four parts: Part A is hospital insurance; Part B is medical insurance that includes a deductible and cost-sharing (usually 20 per cent); Part C, called Medicare Advantage, is for beneficiaries of Parts A and B that opt to use managed care plans; and 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 or through a private insurer or Medicaid (if eligible). As a result, health-care spending in Medicare households can be high, comprising 15 per cent 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 2012 were \$572 billion, 3.5 per cent of US GDP.

Service coverage: The federal government administers the Medicare programmes. Part A helps cover most inpatient care in a hospital and certain care in a skilled nursing facility, certain home health-care services and hospice care. Part B helps pay for certain medically necessary services (including physician visits and medical equipment and supplies) and some preventative services that Part A does not cover. Part D helps pay for some medicines, although a coverage gap 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 it 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 of their greater longevity. 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 'dualy eligible' for Medicaid – meaning they qualify for and receive both – which helps pay for long-term care services in nursing facilities. Women were 56 per cent of those receiving Medicare and 62 per cent of those using both Medicare and Medicaid in 2010.

Sources: Center for Budget and Policy Priorities 2013; Centers for Medicare and Medicaid 2014 (Tables 1, 19 and 22); Kaiser Family Foundation 2012b and 2013e; Medicaid.gov 2013a and 2013b; Medicare.gov 2013a and 2013b; and National Women's Law Center 2012.

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