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

UN WOMEN

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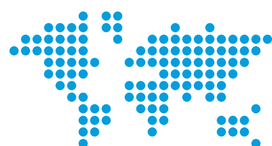

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SUMMARY

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

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

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