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The Patient Protection and Affordable Care Act: Why It Is Important for Women's Health

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Introduction

The United States has held the unflattering distinction of entering the 21st century as the only highly developed country without a national health insurance program that makes health care available to all regardless of gender, income, and other personal characteristics. In a country founded on the democratic ideals of a “classless society,” a former U.S. vice president with generous benefits can receive an artificial heart and subsequently, a heart transplant (Altman & Grady, 2012), while a low-income woman cannot get coverage for maternity care.

President Barack Obama ended this kind of disparity in access to health care on March 23, 2010, when he signed into law the Patient Protection and Affordable Care Act, commonly known as the Affordable Care Act (ACA). The act culminates a 100-year history of political and legislative efforts to provide health insurance coverage for every American. Starting with Theodore Roosevelt who made national health insurance coverage a campaign issue in 1912 (Mauersberger, 2012), through President Bill Clinton who proposed ambitious health insurance reforms in 1993, and finally ending with President Barack Obama, every Democratic president and many Republican ones have tried to address the health care access dilemma in the United States (Andrews, 2012). The hard won battle for passage of the ACA which pitted Democrats against Republicans, was viewed by some as an historic advance in social justice comparable to the establishment of Medicare and Social Security (Pear & Herszenhorn, 2010). Before the ink was dry on the president's signature, however, Republicans were strategizing the law's demise, threatening repeal and lawsuits.

The Supreme Court deliberated on the constitutionality of the ACA during spring 2012, while liberals and conservatives alike waited anxiously for the outcome. The Court's decision at the end of June 2012 affirmed the law's requirement that individuals obtain health insurance coverage (the individual mandate). The Court also ruled that expansion of Medicaid—an important provision of the act to extend health insurance coverage to low income persons—is a state choice, not a requirement (Andrews, 2012). According to a Forbes article, “women in particular should pop the champagne and celebrate” because of the Court's decision (Bryce, 2012).

The ACA is especially important to women who tend to have more involvement with the health care system over their lifetimes than do men. Women in general are responsible for coordinating the health care needs of children, spouses and aging parents. Younger women

require more health services during their reproductive years; older women are the primary users of long term care services (Robertson, Squires, Garber, Collins, & Doty, 2012). Women face greater barriers than men in obtaining health insurance coverage. Approximately 1 in 5 women (18.7 million) were uninsured in 2010 (Robertson, et al., 2012).

This article addresses health insurance coverage, its impact on health, the particular challenges women have confronted in seeking coverage, and the impact of the ACA on these issues. It also addresses the foundational role women leaders have played during the past two centuries in shaping the ACA's focus on women's health.

Women's health movements leading to the ACA

Carol Weisman (1998), in her book, *Women's Health Care: Activist Traditions and Institutional Change*, chronicles the growing awareness of women's health needs in successive efforts or waves starting with the Popular Health Movement of the 1830s to 1840s. The series of waves which Weisman (1998), has labeled the "women's health megamovement," coincided with the era's social movements as well as advancements in medicine. In each of the waves, women activists often resisted traditional medical opinion and offered alternatives to medical practices. For example, during the late 19th century (because of a presumed linkage between the uterus and the brain) dominant medical opinion favored limiting women's physical and mental activities, especially their formal education, in order to preserve their reproductive capacity and to protect the health of their gestating and future children (Weisman, 1998, p. 50). Women doctors in contrast taught that menstruation, pregnancy and menopause were normal female functions and stressed the importance of exercise, useful work and activity, and loose-fitting, comfortable clothing (Weisman, 1998). Often women doctors became leaders of the next wave of the women's health megamovement. The strategy and legacy of each of the waves was education through women's self-help groups, lectures, and publication of health manuals.

Two principal and parallel women's health movements during the Progressive Era at the beginning of the 20th century focused on maternal and infant mortality and on the legalization of contraception and abortion (Weisman, 1998). While reproductive health, including contraception and abortion, have been salient issues in successive waves and have occupied the political agenda since the late 19th century, the concerns and accomplishments in that aspect of women's health are not discussed here. The public policy response to the maternal and infant mortality focus was the Sheppard-Towner Act, through which the federal government provided funding

for maternal and child health services (Weisman, 1998). This act set the stage for successive government policies up to the present, including the Affordable Care Act, that support maternal and child health.

The Women's Health Movement through 1960s and 1970s occurred simultaneously with social activism around civil rights and the Vietnam anti-war movement. This period was a turning point for women's health. According to Weisman (1998)

Unlike reformers in previous episodes of women's health activism, these women did not focus on maternal health or on their health in relation to their actual or potential children. Rather they viewed their health as essential to their full social participation, and they argued that they had a right to the health care they demanded and the right to make informed decisions about all aspects of their care (p. 72).

As in previous waves the principal strategy women activists used to help other women claim health as a right, was education via lectures, women's support groups, and health manuals. One of the most significant health manuals emerging from the period was the 1970s publication of *Our Bodies, Ourselves* by the Boston Women's Health Book Collective. Now in its ninth edition, the book covers a range of issues important to women including chapters on the politics of women's health and navigating the health care system (Boston Women's Health Book Collective, 2011). The Women's Health Movement inspired creation of alternative health care delivery organizations that more specifically addressed women's needs, such as birthing centers and community clinics (Weisman, 1998).

Throughout the latter part of the 20th century, as women attained positional power in business, professions, and government they increased their potential to effect institutional change. Women in Congress used their increasing numbers as well as leadership positions on important committees to advance public policy that addressed women's issues. Fifteen congresswomen organized the Women's Caucus in 1977; members renamed it the Congressional Caucus for Women's Issues (CCWI) in 1981 and invited male colleagues (Women's Policy Inc.). By 1992 there was such a significant increase in the number of women elected to Congress, it was dubbed the "Year of the Woman" (Baird, 2010).

During the early years of the Caucus, congresswomen did not have unanimity on how best to serve the needs of women. They differed on what those needs were or how best public policy could serve them (Hawkesworth, Casey, Jenkins, & Kleeman, 2001). The CCWI coalesced

around women's health during the late 1980s when Caucus members learned of the National Institutes of Health's (NIH) failure to implement its own policy to include women subjects in federally funded research. One of the co-chairs of the Caucus, Senator Olympia Snowe (R-ME), whose mother had died from breast cancer, was particularly incensed that the NIH had funded research on the link between obesity and breast cancer in a pilot study that included only men as subjects (Epstein, 2004). The CCWI's first comprehensive legislative initiative on women's health was the Women's Health Equity Act (WHEA) of 1990. WHEA provisions addressed inclusion of women in clinical research trials, access to health services, and prevention of breast and cervical cancer (Blumenthal & Wood, 1997; Weisman, 1998).

The CCWI heightened attention to women's health issues in the 103rd Congress (1993-1994), which coincided with the start of President Bill Clinton's first term in office. Early in the session as President Clinton kicked off his health insurance reform initiative, the Caucus circulated principles that had been advanced by a coalition of nearly 100 women's organizations. The principles addressed issues such as services that should be included in a health benefits package; encouragement of women as service providers; elimination of gender stereotyping that could hamper diagnosis and treatment of medical conditions; and support for research that would promote good health and prevent disease in women (Hawkesworth, et al., 2001, p. 31). Despite failure of the Clinton reform proposal, the Caucus achieved bipartisan focus on women's legitimate health needs, which would not have been recognized otherwise. Hawkesworth et al. (2001) recorded the comments of one lobbyist regarding the 103rd Congress:

... I think the impact of the women ... was shown most clearly at a hearing that Barbara Mikulski chaired. That was my favorite hearing... because it was very bipartisan. It wasn't Republican and Democrat, it was all the women in the Senate. All of a sudden there were enough women in the Senate to fill up an entire podium, which had never happened before. They were very united and they felt themselves (as they articulated) very empowered to do something as a group.... The focus was very much on breast cancer and cervical cancer and preventive health screenings.... Somebody needed to do it, and the men weren't doing it...(p. 32).

Congresswomen in the 111th Congress, particularly Senator Mikulski, brought women's health into focus during the debate on coverage provisions of the ACA. Among the most significant

benefits of the act are 22 preventive health-screening services specific for women, for which there are no out-of-pocket costs.

Health insurance—who has it; who does not

When President Clinton proposed major health insurance reform in the early 1990's approximately 40 million U.S. residents (1 in 7 persons) were uninsured (DeNavas-Walt, Proctor, & Smith, 2010). No meaningful attempt was made in the next administration to address the plight of the uninsured. President George W. Bush repeatedly vetoed bipartisan legislation to extend health insurance coverage to more children through the State Children's Health Insurance Program (Jacobs & Skocpol, 2010). By the time President Obama was inaugurated and made health care reform the legislative centerpiece of his first year in office, the number of uninsured persons in the U.S. had grown to 50 million (1 in 6 persons) (DeNavas-Walt, et al., 2010).

Contrary to what many may assume, individuals lacking health insurance are not only unemployed persons or low-income workers. As Katherine Swartz (2006) puts it bluntly, "If you want to have a career in broadcasting, journalism, advertising, graphic design, filmmaking, or interior design, prepare to live without health insurance" (p. 15). Factors that have affected the current pattern of health insurance coverage include the changing economy; shifts in employer-employee relationships resulting in fewer people being permanent employees; falling birthrates; changing marital patterns; and expanded public programs (Swartz, 2006).

More than half the U.S. population (55 percent) obtains benefits from employment-sponsored health insurance plans. The balance of the insured population (approximately 31 percent), are covered by public sources that may include Medicare, Medicaid, or Military health care (Mauersberger, 2012). According to a 2011 Bureau of Labor Statistics survey, 70 percent of all private industry workers had access to health insurance benefits through their employers (Mauersberger, 2012). Not all workers enroll in the benefit, particularly low-wage workers for whom premium sharing may be too costly.¹ Part time workers may not be eligible for employer-sponsored health benefits.

¹ Low-wage earners are defined as those in the lowest tenth wage percentile, which is \$8.25 per hour for private industry (Mauersberger, 2012).

Steep increases in health care costs² have caused steep increases in health insurance premiums as well. While the number of large firms (200 or more workers) offering health insurance benefits has remained stable, the percentage of smaller firms offering such benefits dropped from 67 percent in 2001 to 59 percent in 2011. During this same time period, the average annual premium of a family plan rose from \$7,061 to \$15,073, an increase of 113 percent. Employees experienced even greater premium sticker shock, with their portion of the premium rising 131 percent on average. In 2011, employees with family coverage paid on average, 28 percent of the premium; those with individual coverage (averaging \$5,429 per year) paid 18 percent of the premium (The Kaiser Family Foundation and Health Research and Educational Trust, 2012).

Individuals who do not have access to employer-sponsored health insurance or other group insurance, and who do not meet eligibility requirements for public health insurance, may also find insurance in the private, nongroup market inaccessible because of cost or because of a preexisting condition (Institute of Medicine, 2009).

Women's experience in the health insurance market

Women face more challenges than men in obtaining health insurance coverage. Women are more likely to have coverage as a dependent on a spouse's plan and are therefore dependent on the spouse's employment. Women generally have lower incomes than men and therefore have more difficulty meeting the employee share of the premium. As is true for men, women unable to obtain health insurance coverage through an employer-sponsored plan, may want to purchase it in the individual, nongroup market. Women, however, may face gender rating—the practice of charging women more than men for the same type of coverage. In states that allow the practice, 92 percent of the best-selling insurance plans charge women 10 to 80 percent more in premiums than men of the same age. Furthermore, only three percent of those plans offer maternity coverage (National Women's Law Center, 2012).

Glied et al.(2008) found that in the period between 1980 and 2005, working age women (25 to 64 years) experienced a variety of social and economic changes that affected their health insurance coverage. By 2005, one in two women were full time workers, up from one in three in 1980 (Glied, et al., 2008). Women who had employer-sponsored coverage were increasingly

² Between 2000 and 2010 per capita health care expenditures rose 72 percent, from \$4,878 to \$8,402 (The Henry J. Kaiser Family Foundation, 2012)

likely to have the coverage in their own right rather than as dependents. Although 72 percent of women were married in 1980 and thus eligible for coverage under a spouse's health insurance benefit, the proportion of women who were married dropped to 64 percent in 2005 (Glied, et al., 2008). More women were able to obtain coverage through Medicaid because of program expansions between 1980 and 2005. Welfare reform legislation in 1997, however, reduced Medicaid coverage for some women (Glied, et al., 2008).

Why having health insurance matters

According to the Institute of Medicine (IOM) (2009), "There is a chasm between the health care needs of people without health insurance and access to effective health care services. This gap results in needless illness, suffering and even death" (p. 2). Uninsured adults with chronic conditions such as cancer, congestive heart failure, diabetes, heart disease, and hypertension are likely to experience worse outcomes than adults with insurance. Further, uninsured adults suffering serious illness or trauma are less likely than insured adults to fully recover and are at greater risk of mortality (Institute of Medicine, 2009).

Women tend to have higher out-of-pocket health care expenses and use more health care services than men (Patchias & Waxman, 2007). A recent Commonwealth Fund survey found that more than 60 percent of women with incomes below 200 percent of the poverty level reported cost-related problems associated with obtaining needed care during the previous year (Robertson & Collins, 2011). The survey also found that 48 percent of working age women—an estimated 45 million people—reported not filling a prescription, skipping a medical test or treatment, or experiencing a medical problem for which they did not seek treatment (Robertson & Collins, 2011). Survey responses indicated that 79 percent of insured women had a mammogram in the previous two years, compared with only one-third (31 percent) of women without insurance (Robertson & Collins, 2011).

What difference does the ACA makes

The Patient Protection and Affordable Care Act addresses access to health insurance and market reforms; required coverage of health care services; and health delivery system reform (Whitehouse, 2012).

Health insurance and market reforms

In brief, the ACA requires U.S. citizens and legal residents to obtain health insurance coverage through an employer-sponsored plan, a state health-insurance exchange, or through the state Medicaid program by 2014.³ Subsidies will be available for individuals and families with incomes between 133 and 400 percent of the federal poverty level (The Henry J. Kaiser Family Foundation, 2011). The logic to this requirement is that when everyone pays into the insurance system, premiums will become more affordable for everyone.

The law imposes insurance market rules that ensure individuals will not be refused coverage because of preexisting conditions or other personal or demographic characteristics; coverage cannot be rescinded; premiums will not be adjusted for gender; and coverage cannot be limited by a dollar value of coverage. Insurance companies must commit at least 80 percent of the premium dollar to health care services (The Henry J. Kaiser Family Foundation, 2011).

Covered services

Health care plans offered through the state-based health-insurance exchanges will be required to cover a set of essential health care services—the details of which are left to the states—within the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (HealthCare.gov, 2012a). Adults and children will have access to specific screening tests with no out-of-pocket costs. Women will have access to an additional 22 screening services⁴ beyond those specified for adults (Committee on Preventive Services for Women & Board on Population Health and Public Health Practice, 2011; HealthCare.gov, 2012b).

³ Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8 percent of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples) (The Henry J. Kaiser Family Foundation, 2011).

⁴ Preventive screening services for women are listed at <http://www.healthcare.gov>

Delivery system reform

The ACA emphasizes providers' roles in improving health system efficiencies so as to reduce the rate of increase in health care costs. These efficiencies include paying for therapies that are proven to be effective, and covering preventive measures that can reduce the need for downstream medical intervention. Incentives are designed to encourage physicians to help patients obtain necessary care whether it is preventive care or avoidance of complications from chronic conditions, through care coordination and improved sharing of medical information (Kocher, Emanuel, & DeParle, 2010).

What difference does the ACA make for women's health

Women are already realizing some benefits of the ACA and more will be available to them as the act becomes fully implemented. The following benefits are among the most significant: lowered cost barriers to care; access to free preventive and screening services; direct access to obstetrics and gynecology services without a referral from a primary care provider; and young adults can be covered under their parents' plan until the age of 26. Until the ACA is fully implemented, women can enroll in a state (if available) Pre-Existing Condition Insurance Plan with affordable premiums and limits on out-of-pocket costs if they have been unable to purchase private insurance because of being pregnant, having had a cesarean section delivery, or are a survivor of domestic violence. Women who are nursing and employed by companies with 50 or more employees are entitled to reasonable breaks from work to express breast milk; they must be provided with a private place in which to do this for the first year after their child's birth (Collins, Rustgi, & Doty, 2010).

Women covered by Medicaid will have access to expanded services that include smoking cessation support for pregnant women; care provided by freestanding birthing centers; family planning services based on income eligibility; and home visits by nurses and social workers for families with children. Older women covered by Medicare will have drug coverage for the "doughnut hole," the uninsured portion of the Medicare Part D benefit, as well as free age-appropriate screening services (Robertson, et al., 2012).

Conclusion

The ACA has been compared to other major social legislation such as Social Security and Medicare that have had profound effects on people's lives. Women leaders and activists during

the past two centuries, and particularly women in Congress during the past 30 years, have contributed to the shape and content of the ACA as it will affect women's health. The ultimate goal of the ACA is a stronger economy through a healthier population and more efficient use of health care resources. Women will play a pivotal role in bringing that goal to fulfillment by meeting their own health needs as well as coordinating health care services for their children, spouses and aging parents.

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