THE EFFECTS OF THE AFFORDABLE CARE ACT ON WOMEN'S HEALTH

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Gabriela I. Garcia

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Gabriela I. Garcia

Thesis Supervisor:

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Jose A. Betancourt, Dr.PH
Associate Professor, School of Health Administration

Approved:

_____

Heather C. Galloway, Ph.D.
Dean, Honors College

Abstract:

The Affordable Care Act of 2010 was passed to address the growing healthcare disparities in the United States. Many provisions of the law have only been implemented since 2014, and their impacts are continually being assessed. Women play critical roles in every civilization on Earth, yet often face adversity and discrimination in multiple realms, including the healthcare system. This essay examines the impacts the Affordable Care Act has had on women's health thus far, and addresses existing healthcare disparities in the United States and their association with social determinants of health.

Introduction:

The United States is one of the wealthiest and most advanced countries in the world, and consistently ranks at the top in categories such as research output and medical technology. Medical advancements such as vaccines, organ transplants, and preventative screenings have allowed the average life-expectancy to increase in a very short amount of time. Although the United States is a leader in medical advancements, the American health care system is plagued by inequities that cause some groups to lead shorter and more unhealthy lives. Sophisticated treatment options are readily available throughout the United States, but they are not easily accessible for many Americans. Innovations in medical technology have been accompanied by substantial increases in healthcare costs and difficulties obtaining adequate care. Although healthcare has been a controversial political topic since the beginning of the 20th century, little legislation has been passed to help reform the current system. The major policies that govern the current healthcare system are the Social Security Amendments of 1965 and the Patient Protection and Affordable Care Act (ACA) of 2010. Many provisions of The Affordable Care Act have only been in place since 2014, yet considerable impacts can already be seen throughout the country. Despite the substantial progress that has been made in medicine and public health throughout history, health disparities still effect the lives of millions of Americans every day.

The private health insurance industry in America operates similarly to any other for-profit market, meaning that people who can afford to pay higher prices get better benefits. Buying a health insurance policy in the United States is comparable to buying an automobile. More expensive vehicles are built from higher-grade materials and offer

more luxuries than less expensive vehicles. Although a cheaper vehicle may not offer the same luxuries, it will still be able to take an individual to the same destinations that an expensive car could. Unfortunately, this is not the case for people who can not afford health insurance. Paying a higher premium typically entails having a larger network of physicians to choose from, paying less for treatments and medications, and an increased chance of living a longer, healthier life. According to a report published by the Kaiser Family Foundation, a non-partisan healthcare organization, 49% of Americans receive health insurance sponsored by their employer (Kaiser Family Foundation, 2017). Approximately 35% of the population are insured by public health insurance, and 9% of citizens remain uninsured (Kaiser Family Foundation, 2017). Americans who are self-employed, under 65 years old, and do not qualify for Medicaid in their state must purchase health insurance directly from a private insurer, or the federally regulated marketplace, *Healthcare.gov*.

Health disparities in the United States are caused by a multitude of external factors, often referred to as the social determinants of health. Social determinants of health are cultural and environmental conditions that place certain groups at an increased risk for adverse health outcomes (Gehlert et.al, 2008). The social determinants of health can be split into two main categories: upstream and downstream. Upstream determinants are characteristics of the social environment such as discrimination, government policies, socioeconomic status, neighborhood violence, and environmental pollution (Gehlert et.al, 2008). These factors occur on a macro scale and, can not be avoided or inhibited by the individual. Downstream determinants are those that occur at the level of the individual as a result of exposure to adverse upstream determinants, such as diagnosis of a chronic

illness. Upstream interventions are implemented to prevent risks and stop unfavorable health outcomes before they occur. In contrast, downstream interventions are typically used to prevent reoccurrence or subdue the effects of a disease after it has been diagnosed. In the case of breast cancer, an upstream intervention would include having regular access to screening services, while a downstream intervention would be treatment to slow down the spread of breast cancer. Healthcare disparities are more apparent in populations that have been historically marginalized in the United States such as African-Americans, Latinos, Native Americans, members of the LGBTQ+ community, and people of lower socioeconomic status. People in these groups have been found to have higher mortality rates than those from more privileged groups. For example, in 2004 23.8 - 31.8 per 100,000 White women died from breast cancer, compared to 67.9 - 75.9 per 100,000 Black women during the same time period (Gehlert et. Al, 2008). Both groups of women were living in the United States at the same time, meaning that the same treatment options were likely available, however Black women experienced significantly higher mortality rates than White women. Availability of a treatment does not equate to accessibility of the treatment. Both groups of women may have had the same treatment options available to them, but white women were less likely to face barriers that may impede them from receiving the treatment. The social determinants of health play a substantial and complex role in the health of communities and individuals; it is important to note that these factors have only recently become a major focus of public health research.

Women are an integral part of any society, and often play multiple roles in their communities. Today it is common for women to be jobholders, educators, and caregivers

for their families. For decades, American women were not granted the same rights or social status as men. The political gains that came from the Women's Suffrage and Feminist Movements helped women propel their social and political identity. Although women have advanced as a whole, there is still much to be done to diminish the prevalence gender inequality in the United States. Women are still forced to fight for basic rights such as equal wages, reproductive choice, and accessible healthcare. The rights and opinions of women have been excluded from major pieces legislation such as the United States Constitution, which never explicitly mentions the word "women" within its pages. This lack of representation in government has perpetuated the mistreatment and dismissal of women and their health in American culture. Healthcare legislation will inevitably affect every American at some point in their lives. Women require specialized health services such as pre-natal care, contraception, and routine cancer screenings beginning at the start of their reproductive years. Along with requiring specialized healthcare services, studies have shown that women have more interactions with the healthcare system over their lifetimes than men (Bertakis et.al, 2000 & Gunja et.al, 2017).

History of Healthcare Reform

During the Industrial Revolution many Americans began relocating to urban cities in search of new career opportunities. At this point in time medical technology was extremely limited, which meant that getting struck by disease could easily result in death or disability. The lack of medical technology meant that the costs of healthcare treatment remained relatively low and the need for health insurance was not yet apparent. In the early 20th century, work-related injuries and illness kept people from going to work. At this time, lost wages caused by illness and injury cost people more than healthcare. As the country became more industrialized, work-related injuries and the spread of infectious diseases increased due to lack of universal safety and sanitation standards, and urbanization. Americans who were unable to work due to disability, chronic illness, or old age became a major societal concern during the Great Depression. In 1935, President Franklin D. Roosevelt signed the Social Security Act into law. The policy established pensions for retirees over 65 years old, granted financial assistance to needy children, expecting mothers, and the disabled, established unemployment insurance, and allocated federal funding for state-run public health programs (DeWitt, 2010). During World War II, FDR signed the Stabilization Act of 1942 which established a national wage freeze that prohibited employers from issuing bonuses or raises to their employees. To compensate for controlled wages, employers began offering health insurance benefits to their employees. This tactic quickly gained popularity amongst private insurance companies, employers, and the federal government. Shortly after the passage of the Stabilization Act, President Roosevelt signed the Revenue Act of 1942. Under the Revenue Act, companies faced tax rates ranging from 80-90% on all profits that exceeded

those before the war (Mihm, 2017). The law also established that funds spent on employee health benefits could be deducted from the overall revenue of a business. This led to businesses spending less on federal taxes, and increases in healthcare coverage among members of the working-class. The role of employer-sponsored health insurance was further solidified in 1943 when the Internal Revenue Service declared that employees would not have to pay taxes on benefits they receive from their employer, making employer-sponsored insurance more affordable than plans available in the individual market (Caroll, 2017). At first glance, these polices may seem to influence only economic aspects of society, but their impacts reach far beyond the economic sector. These laws unintentionally shifted the structure of the healthcare system by promoting mutualistic interactions between employers and insurance companies. Employers were able to reduce their taxable income, while health insurance companies were able to sell more plans and earn more revenue. Although the laws are not healthcare-related in nature, shortly after their passage, the percentage of Americans with health insurance rose from approximately 9% in 1940, to over 50% in 1950, and over two-thirds in 1960 (Caroll, 2017).

The next successful attempt at health care reform came approximately 30 years after the establishment of Social Security. The passage of the Social Security Amendments of 1965 represent a historic victory for healthcare reform as they established the first and only public health insurance programs in the United States, Medicaid and Medicare. Medicare is a public health insurance program available to citizens aged 65 and older. The basic Medicare is funded by pay-roll taxes, but enrollees have the option of adding additional benefits at additional costs. Medicaid is a public

insurance option that assists low-income populations under the age of 65, and is jointly funded by the state and federal government. Medicaid eligibility is determined by income or number of dependents, and requirements vary between states.

The Affordable Care Act (ACA) is the most recent piece of legislation passed in response to growing healthcare disparities in the United States. The ACA was passed with intent to reform three major components of the American healthcare system: access to care, cost of care, and quality of care (Blumenthal, Abrams, & Nuzum, 2015). In order to decrease inequities in the healthcare system, the ACA takes on a unique approach of targeting both upstream and downstream determinants of health. Upstream interventions in the policy include multiple methods to address health coverage gaps in various populations and increasing accessibility to primary and preventative care services. To address the gaps in the young adult population, a provision was added to allow dependents between the ages of 19-25 to remain covered under their parent's insurance plan. The ACA required that large employers offer healthcare benefits to full-time employees in order to address coverage gaps in the working population. Self-employed Americans and small-business owners were originally required to purchase their own insurance plan or pay a tax penalty for being uninsured under the individual mandate portion of the law. The ACA sought to increase resources for this population by offering premium tax credits to some, and establishing an online marketplace that allows consumers to compare and purchase ACA-compliant health insurance plans. To assist low-income populations obtain coverage, Medicaid eligibility was expanded to all Americans under the age of 65 that earned below 138% of the FPL. The ACA is the first federal law that included mandates specifically to improve women's health. Under the

ACA, private insurance companies must cover all costs related to obtaining various forms of FDA-approved contraception and preventative health services, including pre-natal care.

The Affordable Care Act and Healthcare Access for Women

Obtaining health insurance can be a rather difficult undertaking for the average American, especially one who may not be familiar with insurance terminology or the organization of the health system. A critical component of the Affordable Care Act is the expansion of Medicaid to all individuals earning 138% or less than the federal poverty line regardless of age, sex, number of dependents, or disability status (PPACA, 2010). In 2012 the Supreme Court ruled that the Medicaid expansion provision was unconstitutional, giving states the freedom to decide their own eligibility requirements for Medicaid. Unlike Medicare, Medicaid is financed by both state and federal funds. This joint financial responsibility gives the states complete control of how Medicaid funds get distributed within their boundaries. As of February 2019, 37 states including the District of Columbia have chosen to expand Medicaid in accordance with ACA regulations (Kaiser Family Foundation, 2019). However, 14 states, including Texas, have opted out of expanding the program. In the majority of states that have opted out of expanding the program, only parents and expecting mothers are eligible to apply for Medicaid coverage (Kaiser Family Foundation, 2019). Medicaid-eligible parents in many of these states must earn less than 50% FPL, which equates to $8,532 for a family of three (Kaiser Family Foundation, 2019). Texas has the strictest eligibility requirements for parents in the nation. A family of three in Texas is only allowed to earn 17% of the FPL, or $3,626 a year, in order to apply for Medicaid (Kaiser Family Foundation, 2019). A childless adult living in a Medicaid unexpanded state is typically ineligible to apply for coverage regardless of how low their income may be. In Texas and other non-expanded states, a childless adult can earn $0 a year, and remain ineligible for Medicaid coverage. This is a

stark contrast to Americans living in Medicaid expanded states, who may earn up to $29,435 for a family of three, and up to $17,236 for childless adults and still qualify for the program (Kaiser Family Foundation, 2019). Variability in Medicaid eligibility requirements throughout the United States is a critical factor that contributes to health inequities.

Along with the expansion of Medicaid, the Affordable Care Act aimed to increase coverage in the young-adult population by implementing the dependent coverage provision. Adults in their early twenties have consistently had the lowest rates of health coverage of any age group in the United States (Sommer et.al, 2013). This portion of the law mandated private insurance companies to permit young adults to remain covered as dependents under their parents' health insurance policy until the age of 26, which elongated coverage by as much as seven years (Sommers et.al, 2013). The dependent coverage provision is significant being that it is the first federal law to expand coverage amongst privately insured individuals. Before this provision went into effect, insurance companies dictated who could be considered a dependent and how long they could remain insured. It was common practice for insurance companies to allow full-time college students to remain covered under their parents' policy (Sommers et.al, 2013). This trend left various subgroups of young adults without health insurance; part-time college students, nonstudents, working adults without employer-sponsored benefits, and the unemployed were left with limited options once they "aged-out" of dependent coverage.

The dependent coverage provision is a prime topic for researchers being that is was one of the earliest provisions of the ACA to be fully implemented. A study published

by *Health Affairs* examined early impacts in coverage rates and their association with healthcare accessibility in adults between the ages of 19-25, and discovered significant increases in health coverage across all racial and ethnic groups, working and non-working groups, and married and unmarried groups (Sommers et.al, 2013). Researchers also observed a significant decrease in the percentage of adults ages 19-25 reporting that they delayed or forewent healthcare due to cost (Sommers et.al, 2013).

In the decade leading up to the passage of the Affordable Care Act, the rate of uninsured women under 65 increased from 13 percent in 2000, to 20 percent in 2010, resulting in 19 million women without health coverage (Gunja et.al, 2017). Women who were unemployed or ineligible for employer-sponsored benefits often found themselves stuck between a rock and a hard place. In nearly all states, coverage through Medicaid was only available to pregnant women, low-income parents, and women with disabilities. Purchasing a nongroup plan from a private insurer was a daunting task, as there was little regulation in place to protect women from being discriminated against by insurance companies. From 2010 to 2016, the percentage of uninsured women has declined from 20% to 11%, or 19 million women to 11 million (Gunja et.al,2017). While insurance rates have increased for women as a whole, not all subgroups have experienced improvements of equal magnitude. Young women ages 19-34 have experienced the greatest increases in health coverage, which is reflective of the changes created by the dependent coverage provision (Gunja et.al,2017). Compared to White women, low-income women and women of color have traditionally had an increased risk of being uninsured (Karliner et.al, 2016). Women earning less that 200% of the federal poverty line ($ 24,100) have an uninsured rate of 20%, which is much greater than the 7% uninsured rate of women

earning more than 200% of the FPL (Kaiser Family Foundation, 2018). Black women have an uninsured rate of 12%, and Hispanic women have an uninsured rate of 22%, or double the national average (Kaiser Family Foundation, 2018). Geography plays a large role in uninsured rates, since states are permitted to opt out of expanding Medicaid. In Texas, a non-expanded state, 22% of women remain uninsured compared 3% in Massachusetts, an expanded state (Kaiser Family Foundation, 2018). Creating more avenues to health coverage is a critical upstream intervention that has the potential to decrease the prevalence of health disparities among women by increasing both the access and affordability of care.

Health insurance serves as the gate keeper between citizens and the health system. If an individual becomes insured, their interactions with the health care system are bound by the terms of their policy. Insurance policies dictate where an individual can seek care, the treatments the individual can receive, and how much the individual will have to pay. Private insurers are powerful, multi-billion-dollar entities that influence almost all components of the health system. Insurance companies use their influence to negotiate paying lower fees for health services offered by providers. Providers agree to accept reduced rates for their services in exchange for a reliable stream of patients. Unlike people with health coverage, the uninsured have no one to negotiate lower prices for them, meaning they are solely responsible for paying the full amount charged by providers, which impedes on their access and affordability of care.

The Affordable Care Act and Women's Health Outcomes

Before the implementation of the Affordable Care Act, there were no set requirements regarding the specific health services private insurance companies had to offer their clients, meaning that benefits varied greatly between policies and companies. The Affordable Care Act aimed to standardize the health insurance playing field by implementing a provision that mandated private insurers to fully cover the costs of all preventative care services recommended by the U.S Preventative Services Task Force, the American Academy of Pediatrics Bright Futures Guidelines, and the Advisory Committee on Immunization Practices (Patient Protection and Affordable Care Act, 2010). This provision was milestone for many American women, as it included multiple healthcare services utilized solely by women. For the first time in history, both publicly and privately insured women had guaranteed access to many benefits that had once been out of reach or explicitly denied to them by insurance companies. This provision also aimed to shift the focus of the American healthcare system to prevention rather than treatment.

Unlike other industrialized nations, the United States has historically overlooked the critical role of primary care in the health system. Primary care is a multi-faceted field of medicine responsible for establishing long-lasting relationships with patients, coordinating care with other organizations, treating and managing a broad range of health conditions, and educating patients on positive health behaviors and disease prevention (Shi, 2012). Studies have observed that states with higher ratios of primary care physicians to population experienced lower rates of mortality caused by cancer, heart disease, and stoke, increased life-spans, and reductions in low-birth weight rates

(Starfield et.al, 2005). The physician-patient relationship between a primary care physician and the patients they serve is a powerful tool that can be used to improve health literacy, promote positive health behaviors, and catch preventable or curable diseases before they become too severe. Multiple factors can affect the physician-patient relationship such as the communication skills of a physician, language barriers, patient resistance, and level of health literacy (Ha & Longnecker, 2010). The preventative care mandate of the ACA plays a pivotal role in increasing the access and affordability of primary care, but those are not the only factors that determine whether or a not a person can receive the care they need.

Cancer is the second leading cause of death worldwide and was responsible for approximately 9.6 million deaths in 2018 (World Health Organization, 2018). Early diagnosis and increased screenings are two methods that may lead to decreased spending on treatment, greater probability of survival, and less morbidity (World Health Organization, 2018). Cervical cancer is a type of gynecologic cancer characterized by abnormal cell growth in the epithelial cells of the cervix, and is primarily detected using pap tests. When cervical cancer is detected at stage IB1 or sooner, the disease can be cured with surgery in 92% of cases (Ramondetta et.al, 2015). These odds decrease as the cancer progresses. Treatments beginning at stage IB2 or greater are associated with higher costs, adverse side-effects, emotional stress, and a decreased likelihood of survival (Ramondetta et.al, 2012). In order to get a pap test, women must overcome multiple barriers apart from obtaining health coverage. Reliable transportation, knowledge of health system organization, access to a PCP, time off from work or other responsibilities, and cost are only a few factors that affect if and when a woman seeks medical attention.

One study conducted on medically underserved women in Houston Tx, one of the most ethnically diverse cities in America, found that 75% of women diagnosed with cervical cancer in stage IB2 or above did not have a primary care provider (Ramondetta et.al, 2012). Although all women surveyed were eligible for health insurance when the study took place, only 37.1% of women who were diagnosed at stage IB2 or greater had health insurance prior to diagnosis, compared to 60% of women who were diagnosed at stage IB1 or sooner (Ramondetta et.al,2012). This shows that having access to a service or benefit will not reduce health disparities and adverse health outcomes on its own. The health system in the United States is vast and difficult to navigate for many subgroups of women, especially those with low health literacy levels.

Before implementation of the preventative care provision of the Affordable Care Act, insurance companies were not mandated to include pre-natal benefits in their policies. One study conducted in 2012 reported that only 12% of plans available on the individual market offered maternity benefits; as a result, only 44% of women insured under non-group plans had maternity coverage (Gunja et.al, 2017). Despite improvements in medical technology, maternal mortality and morbidity rates in the United States have risen in recent history. From 2000 to 2014, maternal mortality rates doubled from 9.8 to 21.5 maternal deaths per 100,000 live births (Lu, 2018). Maternal mortality is defined as the death of woman while pregnant or within one year of pregnancy due to complication related to or aggravated by pregnancy (Gadson et.al, 2017). Engagement in early pre-natal care is a critical first step to improving pregnancy outcomes. The earlier a woman can receive pre-natal care, the sooner she can be provided with educational support and assessed for health risks. In the United States, maternal

mortality rates are unevenly distributed based on exposure to several social determinants of health. Black women are 3 times as likely to die from pregnancy related complications and child birth (Lu, 2018). Due to the complexity and variation in exposure to social determinants, it is difficult to pinpoint exact causes associated with adverse pregnancy outcomes in minority women. Studies have shown that instances of racism and discrimination may contribute to the lack of health system engagement observed in minority and low-income women (Gadson et.al, 2017). Most maternal deaths are preventable, and typically result from poor communication, issues in the coordination of care between clinicians, inadequate training, and missed or delayed diagnosis (Lu, 2018). Although the Affordable Care Act has opened the gate to pre-natal care, it alone is not enough to get people through the gate. Healthcare providers and public health practitioners must work together to dampen the adverse effects caused by social determinants, and guide women through the barriers that inhibit them from entering the health system.

The Affordable Care Act and Healthcare Costs for Women

Medical debt is the number one cause of bankruptcy in the United States, and is perpetuated by the high costs of care and lack of health insurance (Scott et.al, 2018). Insurance companies operate by charging customers a monthly premium to create a pool of funds used to pay a percentage of healthcare services utilized by contributors. Profits are made when the money paid out to providers is less than the money being put in by consumers. Insurance companies increase their chances of earning more money by covering healthy individuals who typically do not need as many services or medications as unhealthy individuals. Each insurance plan has a network, or list of physicians and healthcare providers their customers may receive treatment from without having to pay more than the percentage listed in their policy. Seeking healthcare services from an out-of-network provider can result in paying higher co-payments and additional fees, regardless of insurance status. Sometimes seeking care from an out-of-network provider is necessary, especially during emergency situations. Catastrophic health expenditure (CHE) is a common measure used to analyze the financial impacts that a health system has on its population (Scott et.al, 2018). A health expenditure is considered to be catastrophic when a household must reduce its normal spending habits for a period of time in order to cope with the cost of a health service (Xu et.al, 2003). CHEs are important because they can affect a household's finances for years. A recent study found that 70-90% of nonelderly, uninsured, trauma patients admitted to U.S hospitals are at risk of catastrophic expenditure (Scott et.al, 2018). Some ways to reduce CHE risks are by increasing health coverage,

providing support and educational resources for disadvantaged groups, or increasing regulation of health care fees.

Women in the United States have been found to forgo or delay medical care due to costs more often than women in other high-income, Western nations such as the United Kingdom and Germany (Munira et.al, 2018). There are various factors that contribute to the high costs of medical treatment such as lack of insurance, seeking care from a physician or organization that is out-of-network, or requiring a service that is not provided under your insurance policy. Forty-four percent of women in the United States were found to have difficulties paying for medical bills along with higher rates payment denial from insurance companies compared to only 2% of women in the United Kingdom (Munira et.al, 2018). Complications in paying off medical bills for American women may stem from low socioeconomic status and lack of government intervention in the health care sector. Prior to the full implementation of the Affordable Care Act in 2014, discrimination against women by insurance companies was a common occurrence (Garrett et.al, 2012). Gender rating is a ploy used by insurance companies to calculate premiums based on gender (Courtot, 2009). Gender rating is associated with women paying higher premiums than men for the same amount of coverage. A report published by the *National Women's Law Center* found that gender rating costs women approximately one billion dollars a year (Garrett et.al, 2012). Another factor that contributed to women paying higher premiums was that private insurance companies often left out maternity coverage or offered it on expensive insurance riders. The ACA is the first federal law that banned discrimination based on gender, pre-existing conditions, and other risk factors. (GAO, 2013).

Increases in health coverage have resulted in more women gaining access to various forms of prescription contraceptives without cost-sharing. Unintended pregnancies account for almost half of the total pregnancies in the United States, and are estimated to cost over $5 billion dollars in direct medical costs (Burlone et.al, 2012). Contraception is a cost-effective upstream intervention that prevents unplanned pregnancies and saves public funds (Burlone et.al, 2012). An Oregon-based study predicted that by increasing cost-free contraceptive access to all women earning 399% of the FPL or below could potentially save the United States $3 billion dollars over the course of five years (Burlone et.al, 2012). Along with saving public funds, privately-insured women are estimated to save between $255 - $248 per year on IUDs and oral contraceptives respectively (Becker &Polsky, 2015). Access to safe and reliable contraceptives has been linked to lower rates of subsequent entry into poverty, higher rates of work-force participation, and higher wages for women (Becker and Polsky, 2015). Although contraceptives have been associated with positive effects on both health and economic factors among women, a recent regulation has given employers the right to deny women this benefit. Recent regulations passed under the Trump administration allow employers with religious or moral objections to use accommodations or exemptions to either reduce or deny contraceptive coverage to women (Behn et.al, 2018). These new regulations also allow employers to pick and choose the types of contraceptives they will cover, potentially restricting more reliable methods such as IUDs or intradermal implants. Although religious freedom is guaranteed to all Americans, women's access to contraception should not be determined by the religious beliefs of their employers.

The individual mandate is among the most controversial provisions of the Affordable Care Act, as it required all Americans to obtain some form of health insurance. Citizens who remained uninsured were subject to pay a tax penalty. This provision incentivized and reinforced the importance of having health coverage. The mandate was included to increase federal revenue to pay for the cost of expanding public insurance and subsidized health insurance plans. In December of 2017 the individual mandate was repealed by the passage of H.R 1, the Tax Cuts and Jobs Act (Glied, 2018). Beginning in 2019, Americans could remain uninsured without facing a monetary penalty. At first, this may seem beneficial as individuals who may not be able to afford a non-group plan will not be forced to pay a seemingly unjust penalty. The individual mandate was included in the Affordable Care Act to encourage high-income individuals who were not eligible for subsidized health insurance to purchase a plan (Glied, 2018). Since the incentive to obtain a non-group insurance plan is gone, experts anticipate the exodus of many healthy, high-income individuals from the non-group insurance pool. As more people leave non-group insurance pools less funding becomes available to cover consumers in poor health, which may lead to increasing insurance premiums (Glied, 2018).

Discussion

The United States health system is a conglomeration of various policies, organizations, providers, and patients; each with a different role and set of goals. Facilitating a functional and productive society begins with maintaining and promoting the health of its members. The health of a population is the groundwork for all other components of a society. When people are unhealthy, they can not participate in society at their maximum potential. The effects of bad health can be observed on both micro and macro scales. At the microscopic level, bad health can be seen in unregulated cell growth, low levels of immune cells, or mutations in DNA. At the macroscopic level, bad health can inhibit people from going to work or earning an education, contribute to social isolation, and cause physical damage to tissues and organ systems. An individual's overall health is a result of both biological and environmental factors. Some individuals suffer from diseases solely dictated by their genetic make-up, while others suffer from diseases due to their exposure to adverse environmental conditions referred to as social determinants of health. An individual's interaction with social determinants is complex, making it difficult to map single determinants with specific disease outcomes. However, the global consensus among public health organizations agrees that exposure to adverse social determinants strongly influences the health outcomes of individuals and communities.

Healthcare reform has been a controversial topic in America for well over a hundred years. Multiple attempts at reforming the health system in the United States have been made, but few have survived through the legislative process to be implemented. The Affordable Care Act of 2010 is the most recent and comprehensive healthcare reform

legislation that currently governs the health system. The ACA is one of the most controversial pieces of legislation, as it challenged many characteristics of the long-established health system in the United States. For the first time in history, insurance companies were mandated to comply with a list of standards set forth by the federal government. Discrimination based on gender, sex, and pre-existing conditions by insurance companies was formally denounced and made illegal. Medicaid received its first major expansion since being established in 1965, which resulted in significant reductions in the national uninsured rate. Although the ACA has made considerable strides in the healthcare sector in its brief history, it is important to recognize that health disparities, especially among women, are still prevalent.

The Affordable Care Act has set the stage for future health reform interventions by opening the gates of health care to millions of Americans, but it can not solve health disparities on its own. Formal legislation is the first of many steps towards creating a better, more equitable health system. A law is put in place to address the legality of what can and can not be done, but it can not implement itself. Police officers are responsible for monitoring highways to implement traffic laws, as public health practitioners are responsible for monitoring health organizations to implement laws like the ACA. Public health practitioners, physicians, providers and lobbyists are responsible for using the provisions set forth by the ACA in order to create innovative solutions to address the gaps that can not be reached by a piece of paper. Along with creating new solutions, public health officials, politicians, and lobbyists are responsible for protecting the progress made under the ACA from threats of repeal by the current administration. Women have experienced significant improvements in both access and affordability of a

wide array of critical health services, which could all be forfeited if law makers decided to repeal the Affordable Care Act. Access to women's health services does not only impact the lives of women; it impacts the lives of their families, friends, and especially their children. Promoting healthy women is the first step to fostering healthy communities for generations to come.

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