

Adequate Assurance or Medical Mediocrity: An Analysis of the Limits on the Affordable Care Act's Application to Women's Health

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ADEQUATE ASSURANCE OR MEDICAL MEDIOCRITY: AN
ANALYSIS OF THE LIMITS ON THE AFFORDABLE CARE
ACT'S APPLICATION TO WOMEN'S HEALTH

INTRODUCTION

- I. HISTORICALLY HIGH COSTS OF HEALTH INSURANCE FOR WOMEN
 - A. *The 1970s Committee for National Health Insurance and the National Women's Health Network: Background—The Protective Laws of the 1960s*
 - B. *The Secretary's Advisory Committee on the Rights and Responsibilities of Women (SACRRW)*
 - C. *Gender Rating*
 - D. *Employer Discrimination*
 1. *The Pregnancy Discrimination Act of 1978—Title VII of the 1964 Civil Rights Act*
 2. *The Contraception Coverage Controversy*
 - II. WHAT THE AFFORDABLE CARE ACT PROVIDES
 - A. *Preventative Screenings and Contraception*
 - B. *Ban on Discrimination for Insurance Premiums and Coverage*
 - C. *Increased Maternity Care*
 - D. *Increased Elderly Women's Care*
 - E. *Financial Provisions*
 - III. OBSTACLES TO THE ACA
 - A. *Women on Parents' Health Insurance Not Covered for Pregnancy*
 - B. *The Respect for Rights of Conscience Act and the Religious Freedom Protections Act*
 - C. *The ACA Explicitly Allows States to Pass Laws Allowing Private Insurers Not to Cover Abortion Costs*
 - D. *Undocumented Immigrant Workers*
 - E. *The Negative Impact of the ACA on Seniors*
 - IV. ACCESS TO HEALTH CARE, BUT NOT CHOICE
- CONCLUSION

INTRODUCTION

Access to health care and insurance for feminine health has been a hard-fought battle since the advent of the women's movement in the 1960s.¹ From maternity leave to contraception coverage to higher

1. Deborah Dinner, *The Cost of Reproduction: History and the Legal Construction of Sex Equality*, 46 HARV. C.R.—C.L. L. REV. 415, 450, 453–54 (2011).

premiums for women as a result of gender-rating, being female has often been treated as a condition by employers, insurance companies, and health-care providers alike.² With the recently enacted Patient Protection and Affordable Care Act (“ACA”), the Obama administration has endeavored to halt the prejudices against women in the health-care market and to provide both preventative and affordable care;³ it is the hope of many that the provisions of the ACA will both improve women’s health and allow women to make choices based not upon financial hindrances, but on what women actually want and need for their health.⁴

Many obstacles, however, stand in the way of all women being given free agency to make the best decisions for themselves and for their health.⁵ State noncompliance, refusal clauses, neglect of multiple demographics, and governmental fiscal concerns all cast a dark cloud over the positive aspects of this law that has been presented to the majority of women as a beacon of light.⁶ In the days and weeks following the Supreme Court’s approval of the ACA, women’s groups and media sites lauded the passage of the act as a historical advancement of women’s rights.⁷ Then slowly but surely, and enhanced by the heated political scene of Fall 2012, flaws in the law and lawsuits regarding controversial provisions began to abound.⁸ Discussion of these issues and loopholes had already been tabled by the Republican

2. Tara Parker-Pope, *Why Being Female is a Preexisting Condition*, N.Y. TIMES WELL BLOG (Mar. 30, 2010, 11:58 AM), <http://well.blogs.nytimes.com/2010/03/30/why-being-female-is-a-pre-existing-condition/>; see also Denise Grady, *Overhaul Will Lower the Costs of Being a Woman*, N.Y. TIMES (Mar. 29, 2010), <http://www.nytimes.com/2010/03/30/health/30women.html?ref=health&r=0> (describing the detriments of the health-care system on women and the potential impact of the Affordable Care Act when the legislation was first introduced).

3. *Health Care Law Gives Women Control over Their Care, Offers Free Preventative Services to 47 Million Women*, U.S. DEP’T HEALTH & HUMAN SERVS. (July 31, 2012), <http://www.hhs.gov/news/press/2012pres/07/20120731a.html>.

4. See, e.g., Marcia Greenberger & Lisa Codispoti, *What Health Reform Means for Women*, 37 SUM. HUM. RTS. 5–7 (2010).

5. Lisa C. Ikemoto, *Abortion, Contraception and the ACA: The Realignment of Women’s Health*, 55 HOW. L.J. 731, 735 (2012); Erin Gloria Ryan, *Whore Pill-Hating GOP Pretending the Whole Supreme Court Upholds Obamacare Thing Didn’t Happen*, JEZEBEL (July 13, 2012, 2:55 PM), <http://jezebel.com/5925872/whore-pill+hating-gop-pretending-the-whole-supreme-court-upholds-obamacare-thing-didnt-happen?tag=holycrap>.

6. See discussion *infra* Part III.

7. See, e.g., *Fact Sheet: Why the Affordable Care Act Matters for Women*, NAT’L P’SHIP FOR WOMEN & FAMILIES, http://www.nationalpartnership.org/site/PageServer?pagename=issues_health_reform_anniversary (last visited Nov. 3, 2013); *The Affordable Care Act: #HealthcareWorks*, PLANNED PARENTHOOD, <http://www.plannedparenthoodaction.org/test-blank-page/health-care-reform-and-women/> (last visited Nov. 3, 2013).

8. *The Cases*, HEALTHCARE LAWSUITS, <http://healthcarelawsuits.org/allcases.php> (last visited Nov. 3, 2013) (listing a total of twenty-two lawsuits to date).

Party prior to the Supreme Court decision,⁹ but once the constitutional validity of the ACA was affirmed¹⁰ these issues and loopholes immediately crystalized, as they were now a certainty and not a hypothetical “what if.”¹¹ Even after the election of President Obama for a second term, many are left wondering how exactly this health-care plan will work.¹²

This Note seeks to expose the various issues that women will face with the enactment of the ACA. The first section examines the women’s movement in relation to the issue of health care and seminal moments that have framed the current health-care climate for women; this section also briefly addresses the issue of “loud” and “quiet” rights in the sense that some health-care issues are given more press and attention because they are in a sense “sexier” than others. The second section outlines the ACA provisions that were specifically targeted toward women, including preventative care, prohibitions against gender discrimination, financial provisions, maternity care, and care for older women. The third section analyzes the multiple obstacles to equal access to care; these obstacles are provisions that have been written into the ACA, such as religious refusal clauses and prohibition of provision of services to undocumented immigrants, as well as outside obstacles, including state noncompliance, and fiscal issues with Medicare. The final section of the Note discusses the future of the law in relation to women’s health care and whether it is conscionable to accept the new provisions of health care that the ACA provides as positives that outweigh the negative application to some demographics.

I. HISTORICALLY HIGH COSTS OF HEALTH INSURANCE FOR WOMEN

A. The 1970s Committee for National Health Insurance and the National Women’s Health Network: Background—The Protective Laws of the 1960s

The protective laws of the 1960s perpetuated a divide among feminists.¹³ One feminist camp advocated for sameness feminism

9. Ezra Klein, *Unpopular Mandate: Why Do Politicians Reverse Their Positions?* NEW YORKER (June 25, 2012), http://www.newyorker.com/reporting/2012/06/25/120625fa_fact_klein?currentPage=all.

10. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

11. Karen Pierog, *States Launch Lawsuits Against Healthcare Plan*, REUTERS (Mar. 22, 2010, 1:21 PM), <http://www.reuters.com/article/2010/03/22/us-usa-healthcare-states-id-USTRE62L3B820100322>.

12. *Affordable Care Act Benefits Begin Roll Out, Including Women’s Preventative Care*, PBS NEWS HOUR (Aug. 1, 2012), http://www.pbs.org/newshour/bb/health/july-dec12/health_care_08-01.html.

13. Dinner, *supra* note 1, at 444.

and one for difference feminism.¹⁴ The difference feminists advocated for protective laws because they felt as though they stopped employers from exploiting women in the workforce and spread the cost that individual women faced by the requirement to spend more time in the domestic sphere to employers instead of cutting women's wages.¹⁵

In contrast, the sameness feminists argued that making sex-specific labor standards only perpetuated gender stereotypes and resulted in lower wages for women as well as a decrease in opportunity.¹⁶ These women rather advocated for equal treatment, which "required the evaluation of individual capacity rather than classification on the basis of group characteristics."¹⁷ Regardless, both protective labor standards and sex-specific standards still placed the burden on women in the realm of child rearing: "[u]nder both the social-protective and equal-treatment regimes, women internalized the cost of pervasive pregnancy discrimination."¹⁸

B. The Secretary's Advisory Committee on the Rights and Responsibilities of Women (SACRRW)

In response to the disparities for women in the employment arena and the lack of benefits given to women, not only through pregnancy discrimination, but in many other areas of women's health, a public committee was formed to examine the policies and programs related to health that had an impact on women.¹⁹ Anne Kasper observes that "[m]any of the insurance issues that are relevant to women today were addressed in the work of SACRRW [Secretary's Advisory Committee on the Rights and Responsibilities of Women]."²⁰ Insurance discrimination due to employment discrimination, lack of coverage for women who stayed at home, and lack of coverage for reproductive health services and preventative care were all issues of the time as they are issues today.²¹

SACRRW developed ten principles for guiding the women's health movement, which have remained relevant to today's discussion of women's health care.²² The most important and relevant of these

14. *Id.*

15. *Id.* at 444–45.

16. *Id.* at 445.

17. *Id.*

18. *Id.* at 446.

19. Anne Kasper, *The History of Health Care Reform and the Women's Health Movement*, OUR BODIES OURSELVES, (Apr. 2008), available at <http://www.ourbodiesourselves.org/book/companion.asp?id=31&compID=68&page=3>.

20. *Id.*

21. *Id.*

22. *Id.*

principles to the institution of the ACA and the barriers against it are cost-sharing, no bias for pre-existing conditions, and a universal system for all to have comprehensive health care based not on familial relationships but on individual status.²³

C. Gender Rating

Even as insurance rights were focused on the goal of obtaining health insurance for women on an individual level, and not in relation to their marital status, or deprived because of their absence from the work force to have a child, gender rating remained a stark issue that increased the cost of health care for women in comparison to men.²⁴ Insurance industry representatives have insisted “women, on average, have higher hospital, physicians’ and other health care costs than men.”²⁵ In the employment market, employers are bound by the prohibitions of Title VII from charging women more for health insurance than men.²⁶ While this is a step in the right direction, many employers are rescinding actual health-care coverage and “providing financial assistance to their employees to purchase coverage in the individual insurance market.”²⁷ As Title VII does not apply in this arena, protections against gender rating were necessary to prohibit sex discrimination in granting insurance policies.²⁸

While the ACA issues a broad ban against any sex discrimination for insurers who receive federal subsidies,²⁹ and while the majority of private insurers will receive federal subsidies to cover low- and moderate-income individuals,³⁰ the policies behind gender rating will still present an issue.³¹ Some insurers claim that gender rating is a business decision and closing the gap will lead to the loss of business from males as their insurance rates will increase.³² Though insurers

23. *Id.*

24. NAT’L WOMEN’S LAW CTR., NOWHERE TO TURN: HOW THE INDIVIDUAL HEALTH INSURANCE MARKET FAILS WOMEN, 4 (2008), available at <http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf>.

25. *Id.* at 9.

26. *Id.* at 6.

27. *Id.* at 9.

28. *Id.*

29. Greenberger & Codispoti, *supra* note 4, at 6.

30. Philip Moeller, *How New Health Insurance Subsidies Will Work*, U.S. NEWS & WORLD REP. (July 27, 2012), <http://money.usnews.com/money/blogs/the-best-life/2012/07/27/how-new-health-insurance-subsidies-will-work>.

31. *Gender Rating in the Individual Health Market*, NAT’L WOMEN’S LAW CTR., <http://hrc.nwlc.org/policy-indicators/gender-rating-individual-health-insurance-market> (last visited Nov. 3, 2013).

32. Robert Pear, *Gender Gap Persists in Cost of Health Insurance*, N.Y. TIMES (Mar. 19, 2012), <http://www.nytimes.com/2012/03/19/health/policy/women-still-pay-more-for-health-insurance-data-shows.html>.

tout this as a legitimate reason for charging women more because of the increased number of claims, the National Women's Law Center has objected that disparities between insurers indicate this justification may not be valid.³³

President of the National Women's Law Center, Marcia Greenberg, noted that "[i]n Arkansas . . . one health plan charges 25-year-old women 81 percent more than men, while a similar plan in the same state charges women only 10 percent more."³⁴ While insurance companies may be justified in their assertion that women's care costs are higher than men's, this disparity is likely the result of a failure on the insurance company's part to cover certain types of care thus creating "higher rates of financial burden from medical care [for women] . . . including higher rates of . . . trouble paying medical bills."³⁵

D. Employer Discrimination

As employer discrimination has been an issue in the spheres of pay, promotions, and other rights of women in the workforce, health insurance and health related issues have also historically caused discrimination against women.³⁶ While Title VII currently prohibits employers from discrimination,³⁷ that was not always the case³⁸ and the debate still continues today as to what employers should be required to cover under health insurance for their female employees.³⁹

1. The Pregnancy Discrimination Act of 1978—Title VII of the 1964 Civil Rights Act

The underpinnings of this act began with *General Electric v. Gilbert*.⁴⁰ This landmark Supreme Court case held that it was not discriminatory to refuse women coverage for pregnancy leave under disability law, as pregnancy was "significantly different from the typical covered disease or disability."⁴¹ In response to this outcome, many

33. NAT'L WOMEN'S LAW CTR., *supra* note 24, at 10.

34. Pear, *supra* note 32.

35. CHERYL WINTER, COVER MISSOURI, WOMEN'S HEALTH COVERAGE AND THE AFFORDABLE CARE ACT (2012).

36. See Dinner, *supra* note 1, at 417–18, 423–24, 427.

37. Civil Rights Act of 1964, Pub. L. No. 88-352 (1964).

38. See Dinner, *supra* note 1, at 243.

39. *Title VII Requires Covered Employers to Provide Contraceptive Coverage*, NAT'L WOMEN'S LAW CTR., (Feb. 9, 2012), <http://www.nwlc.org/resource/title-vii-requires-covered-employers-provide-contraceptive-coverage>.

40. Gen. Elec. Co. v. Gilbert, 429 U.S. 125 (1976).

41. *Id.* at 126.

women and feminist groups responded by filing pregnancy discrimination claims, especially against General Electric given the number of women that the company employed.⁴² The International Union of Electrical, Radio, and Machine Workers (IUE) successfully negotiated claims with multiple employers to change women's contracts to include some coverage for pregnancy.⁴³ General Electric (G.E.), however, remained obstinate in the face of paying for these benefits and the IUE filed a lawsuit resulting in a Fourth Circuit affirmance for the plaintiffs and an appeal to the Supreme Court.⁴⁴

G.E.'s main argument, and the argument of business *amici*, asserted, "the pregnancy exclusion derived from a legitimate economic calculus rather than from sex-based animus."⁴⁵ Defendants here, and those in similar cases, also argued that besides the increased cost of providing pregnancy leave to women, women did not warrant this pay because of their "lesser labor-force attachment."⁴⁶ Further, defendants argued that pregnancy exclusions served rational business interests that maintained insurance plans' solvency, as premiums would have to be raised or other benefits would have to be cut if there were added pregnancy related benefits.⁴⁷ Under defendants' reasoning, pregnancy benefits would serve as a distinct type of severance pay that allowed women to reap these benefits and then choose not to return to the workforce.⁴⁸

Amici and plaintiffs in these cases argued that defendants' justifications lent themselves to unlawful, sex-role stereotypes, and that many women often wanted to return to work, and were indeed economically required to.⁴⁹ They further asserted that women could be forced to pay back their benefits should they decide not to return to work.⁵⁰ The Court did not find these arguments persuasive and in the final appeal held that the exclusion of pregnancy coverage was not discriminatory; the law was deemed facially neutral, not discriminating between men and women, but between pregnant and non-pregnant persons.⁵¹

42. Dinner, *supra* note 1, at 423–24.

43. *Id.* at 424.

44. *Id.*

45. *Id.* at 425.

46. *Id.* at 426.

47. *Id.*

48. Dinner, *supra* note 1, at 425.

49. *Id.* at 427.

50. *Id.* at 428.

51. Gen. Elec. Co. v. Gilbert, 429 U.S. 125, 136–38 (1976) (citing *Geduldig v. Aiello*, 417 U.S. 484 (1974) as the seminal case that provided that pregnancy was different from other disabilities in that it was a voluntary and wanted condition and although confined to women was not a pretext for discrimination).

A few years after this holding, Congress enacted the Pregnancy Discrimination Act (“PDA”) of 1978, overriding *Gilbert*. Essentially, PDA provided that women who took time from work for pregnancy-related purposes were to be treated “the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work.”⁵² PDA provides for pregnancy, childbirth, or related medical conditions.⁵³ A distinct difference from protections provided today, however, is that the law allows any employer to refuse coverage of abortions unless the mother’s life would be in danger.⁵⁴ Thus, although the PDA was a victory for women, it only covered and recognized a sliver of reproductive health—i.e., only reproductive health relating to pregnancy and maternity care and not the myriad of other reproductive health issues that occur outside of child rearing.⁵⁵

2. *The Contraception Coverage Controversy*

After gaining coverage for pregnancy, the next obstacle—an obstacle this Note argues may not be overcome by the ACA—was obtaining contraception and abortion coverage. In the 1960s, “kitchen table conversations” about women’s health were the only place where contraception and abortion were discussed.⁵⁶ The seminal case on this topic is *Eisenstadt v. Baird* in which the Court famously stated: “[i]f the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”⁵⁷ Thus, a right to access

52. The Pregnancy Discrimination Act, Pub. L. No. 95-555 (1978).

53. *Id.*

54. *Id.*

55. *Id.*

56. Ikemoto, *supra* note 5, at 735. A distinction should be made here between women’s health and women’s reproductive health. Advocates for women’s health “defined women’s health in opposition to biological essentialism and the ways in which it shaped medical practices.” *Id.* Advocates in this sphere reject the concentration on only reproductive health as they believe it has concentrated only on abortion to the “near-exclusion of the rest of women’s bodies and women’s lives.” *Id.* Further, reproductive rights link both to women’s civil rights and social issues that arise from contraception and the idea of population control. *Id.* When women’s health, reproductive rights, and women’s rights combine to generally further women’s health and advance their well-being, it is easy to see how some discourses—especially those related to abortion and contraception—would gain the “loudest” advocates while advocating for other issues becomes less intriguing. It is important to keep these competing interests in mind when discussing women’s health care in order to avoid focusing too much on the issues that generate the most heated debates.

57. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

contraceptives was granted.⁵⁸ A right to access, however, does not necessarily mean that every woman has the ability to access—only those who are insured may exercise their right.⁵⁹ Laws advocating for contraception equity only focus on the insured population and ignore the individuals who do not have insurance.⁶⁰

The disparity both between women who are uninsured and women who are denied contraception under their health insurance is sometimes referred to by insurance companies as a “lifestyle” choice or personal responsibility.⁶¹ Supporters of this aphorism advocate the view that “employers as well as government should not be responsible for providing health benefits.”⁶² Below, the discussion addresses whether the ACA actually ameliorates this issue, or whether, while facially providing insurance coverage to everyone for contraception, the ACA actually is a hindrance to women receiving other types of health care *in exchange* for the right to contraception.⁶³ Thus, the argument that the “loudest” of the rights that women advocate for sometimes takes over those “quieter rights” that while not as controversial are still vitally important to women’s health and women’s agency in choosing health care options.⁶⁴

II. WHAT THE AFFORDABLE CARE ACT PROVIDES

A. Preventative Screenings and Contraception

In the realm of reproductive rights, preventative screenings and contraception are perhaps two of the most sought after and important provisions of the law.⁶⁵ Specifically, “[m]ore than twenty million women will get expanded coverage of preventive services—prenatal care, mammograms, pap smears, breast-feeding supplies, testing for sexually transmitted diseases, well woman checkups, immunizations, [and] birth control.”⁶⁶ Perhaps more importantly, women will not have

58. *Id.* at 443, 454–55.

59. Phyllis M. McCandless, *The Fallacy of Mandating Contraceptive Equity: Why Laws that Protect Women With Health Insurance Deepen Institutional Discrimination*, 42 U.S.F. L. REV. 1115, 1116 (2008).

60. *Id.* at 116–17.

61. Ikemoto, *supra* note 5, at 746.

62. *Id.*

63. See discussion *infra* Part III.

64. VALERIE JARRETT & CHRISTINA TCHEN, WHITE HOUSE COUNSEL ON WOMEN & GIRLS, KEEPING AMERICA’S WOMEN MOVING FORWARD: THE KEY TO AN ECONOMY BUILT TO LAST 12 (2012), available at http://www.whitehouse.gov/sites/default/files/email-files/womens_report_final_for_print.pdf.

65. *Id.*

66. Katha Pollitt, *Obamacare(s) for Women*, THE NATION (July 11, 2012), <http://www.thenation.com/article/168833/obamacares-women>.

to pay increased rates for these services because of cost-sharing.⁶⁷ Insurance companies will build the costs into all policies, and assert “these costs are going to be relatively *de minimis*.”⁶⁸ Advocates claim that preventative care is actually cheaper though it may cost more on the front end.⁶⁹ For example, it has been argued that birth control is much cheaper than providing care for a pregnant woman.⁷⁰ Further, women who receive gestational diabetes screenings during pregnancy have a good chance of limiting the costs of taking care of a child with diabetes after the child is born.⁷¹

The contraception provision of the ACA itself is extremely large and facially gives women much more latitude in birth control choices.⁷² Not only is there no copay for birth control, the ACA also mandates that all methods of contraception be covered.⁷³ While “free contraception” has been one of the most praised provisions of the ACA, deemed by blog *Jezebel* as “No Copay Day,” religious groups as well as states may be able to limit this provision.⁷⁴ Further, if a generic is available, even if a woman’s body reacts negatively to it, the insurance company will only cover the generic.⁷⁵ These limits, among others, are discussed further below.⁷⁶

B. Ban on Discrimination for Insurance Premiums and Coverage

Just as cost-sharing decreases the burden on women for preventative care,⁷⁷ insurance companies are also obligated to take away further financial impediments to health care for women. First, insurance companies cannot drop women for getting pregnant, having breast cancer, having a Caesarean, or being the victim of domestic violence.⁷⁸ Second, gender-rating is prohibited by the ACA so that

67. PBS NEWS HOUR, *supra* note 12.

68. *Id.*

69. Ben Finley, *Cloudy Contraception Costs*, FACTCHECK (Feb. 2012), <http://www.factcheck.org/2012/02/cloudy-contraception-costs/>.

70. PBS NEWS HOUR, *supra* note 12.

71. Alexandra Sifferlin, *The 8 Preventative Health Services That Women Start Getting Free Today*, TIME (Aug. 1, 2012), <http://healthland.time.com/2012/08/01/the-8-preventive-health-services-that-women-start-getting-free-today/>.

72. Kat Stoeffel, *My Failed Attempt to Claim My ‘Free’ Obamacare Birth Control*, NEW YORK MAG. (Aug. 6, 2012, 4:10 PM), <http://nymag.com/thecut/2012/08/i-tried-to-claim-my-free-birth-control.html>.

73. Pollitt, *supra* note 66.

74. Erin Gloria Ryan, *Here’s How to Score Copay-Free Birth Control, Coming This Week to a Pharmacy Near You*, JEZEBEL (July 30, 2012), <http://jezebel.com/5928136/heres-how-to-score-your-copay-free-birth-control-coming-this-week-to-a-pharmacy-near-you>.

75. *Id.*

76. *Infra* discussion Part III.

77. *See supra* Part II.A.

78. Pollitt, *supra* note 66.

insurance companies cannot charge women more for their preexisting conditions or for preventative care services that are unique to women, like pap smears and care related to maternity.⁷⁹

C. Increased Maternity Care

Aside from the actual provision of insurance for pregnancy and maternity care, the ACA also bolsters women's rights within the realm of maternity care.⁸⁰ These include breastfeeding supplies, the right to pump, and improved prenatal care.⁸¹ Specifically, the ACA provides women a right to pump at work, breaks necessary to pump, and supplies to do so.⁸² Federal agencies such as the CDC and the Department of Agriculture have campaigned for awareness of the benefits of breastfeeding.⁸³

Further, private and federal organizations have set out campaigns to support prenatal health.⁸⁴ The text4baby program, developed in February 2010, is an example of such campaigns.⁸⁵ For women who sign up, free text messages are sent throughout the mother's pregnancy regarding prenatal health, infant health after the baby is born, and other issues related to maternal care.⁸⁶

D. Increased Elderly Women's Care

A set of "quieter rights" as referred to previously,⁸⁷ the ACA also provides for increased care for postmenopausal women who likely have concerns other than birth control, prenatal care, and maternal health.⁸⁸ One of these provisions is for preventative care, mainly bone-density tests.⁸⁹ The other important benefit provided to elderly women is purported to be more affordable care.⁹⁰ While the longevity of this provision is debated because of cuts to Medicare,⁹¹ the Act does provide

79. *Id.*

80. JARRETT & TCHEN, *supra* note 64, at 13.

81. *Id.* at iv, 15.

82. *Id.* at 15.

83. *Id.*

84. *Health Care Law Gives Women Control Over Their Care*, U.S. DEP'T. HEALTH & HUMAN SERVS. (July 31, 2012), <http://www.hhs.gov/news/press/2012pres/07/20120731a.html>.

85. TEXT4BABY, <http://text4baby.org/> (last visited Nov. 3, 2013).

86. *Id.*

87. *See supra* Part I.

88. JARRETT & TCHEN, *supra* note 64, at ii.

89. *Id.*

90. Greenberger & Codispoti, *supra* note 4, at 5, 7.

91. *Infra* discussion Part III.E.

for a closing of the prescription drug coverage gap—“the doughnut hole.”⁹² Under the old Medicare system, seniors lost coverage for their overall prescription drug coverage that cost “more than \$2,830 but less than \$6,440.”⁹³ What the ACA purports to do is phase out this provision by 2020, and in the meantime, give rebates and discounts to seniors who fall within “the hole.”⁹⁴

Perhaps most importantly, the ACA places a ban on lifetime and annual benefit limits.⁹⁵ This means that insurance plans will no longer be permitted to put a dollar limit upon the services that individuals are allowed to receive.⁹⁶ The ban on lifetime limits is already in place, and in 2014 the ban on annual limits will be instituted.⁹⁷ This provision is especially important for elderly women “because of women’s health care needs, they are at greater risk for reaching an annual or lifetime benefit cap.”⁹⁸

E. Financial Provisions

Finally, not directly related to women’s health, but essential to access for some women, the act provides financial incentives for employers to increase women’s access to health care.⁹⁹ The first of these provisions is a tax credit to small business employers.¹⁰⁰ Because women often work for small businesses, and because small businesses often do not provide insurance because of affordability issues, the ACA provides a tax credit for employers with up to fifty employees when the employer offers insurance to said employees.¹⁰¹

The second of these provisions falls under the “shared responsibility” provision.¹⁰² While employers are not obligated to provide their employees with insurance, if the employee obtains insurance that is federally subsidized, the employer must pay a penalty.¹⁰³ The basic premise of this system is that employers will not want to pay a penalty, they will provide their employees with the necessary insurance, all individuals will contribute to the pool of insurance, and therefore costs will decrease for everyone.¹⁰⁴

92. Greenberger & Codispoti, *supra* note 4, at 7.

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. Greenberger & Codispoti, *supra* note 4, at 7.

99. *ObamaCare: Employer Mandate*, OBAMACAREFACTS, <http://obamacarefacts.com/obamacare-employer-mandate.php> (last visited Nov. 3, 2013).

100. Greenberger & Codispoti, *supra* note 4, at 8.

101. *Id.*

102. *ObamaCare Employer Mandate*, *supra* note 99.

103. Greenberger & Codispoti, *supra* note 4, at 6.

104. *Id.*

III. OBSTACLES TO THE ACA

While the ACA has the potential to provide women with adequate care and decreased costs,¹⁰⁵ there are many aspects of the ACA that increase costs for some as well as leave many demographics with no care at all.¹⁰⁶

A. *Women on Parents' Health Insurance Not Covered for Pregnancy*

The first example is one that has gotten some media attention.¹⁰⁷ Unfortunately, this is not a new issue, as many women would not have been covered under previous plans.¹⁰⁸ First, PDA, while providing maternity coverage to employees and spouses, does not require coverage for dependents.¹⁰⁹ Because the ACA permits dependents to remain on their parents' insurance much longer, specifically until the age of twenty-six, this may lead to a significant number of uncovered pregnancies.¹¹⁰ In this case, it is predicted that more women "will likely become pregnant while on mom and dad's plan" even if they are "married, living on their own, and financially independent."¹¹¹ Further, even though maternity and newborn care are of the "essential health benefits" that insurers are required to provide in small group and individual plans, larger plans, offered at larger companies, are more comprehensive and are not required to provide the essential benefits.¹¹² As many parents are likely to be part of these larger group plans, the issue of lack of coverage arises for these women-dependents.

While it has been suggested that these women-dependents may obtain Medicaid to help pay for their maternity costs, this is further

105. *ObamaCare: Women's Health Services*, OBAMACAREFACTS, <http://obamacarefacts.com/obamacare-womens-health-services.php>.

106. *ObamaCare: Pros and Cons*, OBAMACAREFACTS, <http://obamacarefacts.com/obamacare-pros-and-cons.php>.

107. See, e.g., Amanda Marcotte, *Health Care Reform Leaves Out Young Pregnant Women*, SLATE: XX FACTOR BLOG (Aug. 8, 2012, 1:16 PM), http://www.slate.com/blogs/xx_factor/2012/08/08/aca_and_pregnancy_many_young_women_not_receiving_maternity_coverage.html; Michelle Andrews, *Must Plans Cover Maternity Services for Adult Children?*, N.Y. TIMES PRESCRIPTION BLOG (June 28, 2010, 9:00 AM), <http://prescriptions.blogs.nytimes.com/2010/06/28/must-plans-cover-maternity-services-for-adult-children/>.

108. Michelle Andrews, *Gaps in Maternity Coverage for Some Women Could Grow Under Health Law*, SHOTS: NPR HEALTH BLOG (Aug. 7, 2012, 11:12 AM), <http://www.npr.org/blogs/health/2012/08/07/158296493/health-care-overhaul-creates-gaps-in-maternity-coverage-for-some-women>.

109. *Id.*

110. *Young Adult Coverage*, U.S. DEP'T. HEALTH & HUMAN SERVS., <http://www.healthcare.gov/law/features/choices/young-adult-coverage/index.html> (last visited Nov. 3, 2013).

111. Andrews, *supra* note 107.

112. *Id.*

complicated by where the dependent lives.¹¹³ While the dependent may still live with her parents and qualify for Medicaid, the parents' income is the one that is considered for receipt of Medicaid and is often too high for an award of benefits.¹¹⁴

Some young women may also be able to benefit from the essential health benefits provided from the individual and small group plans that include well-woman visits, gestational diabetes tests, and breast-feeding supplies, but these are dependent upon which insurance plan their parents have.¹¹⁵ This restriction thus has the capability of financially crippling young mothers as well as the parents who support them.

B. The Respect for Rights of Conscience Act and the Religious Freedom Protections Act

The Respect for Rights of Conscience Act of 2011 provides in pertinent part that:

[a] health plan shall not be considered to have failed to provide the essential health benefits package . . . [if] providing coverage . . . of such specific items or services is contrary to the religious beliefs or moral convictions of the sponsor, issuer, or other entity offering the plan.¹¹⁶

Likewise, the Religious Freedom Protections Act provides that the ACA may not require "any individual or entity to offer, provide, or purchase health insurance coverage for a contraceptive or sterilization service, or related education or counseling, to which that individual or entity is opposed on the basis of religious belief or moral conviction."¹¹⁷ If an organization, entity, or individual wishes to challenge any provision of the ACA with these acts as support, it would have a private right of action in federal court.¹¹⁸ While these provisions do provide for necessary freedom of religion allocations to individuals and organizations,¹¹⁹ they may prove to be substantial bars to women obtaining

113. Michelle Andrews, *Parents' Insurance Covers Children Up To Age 26—But Not for Pregnancy*, WASH. POST (Aug. 6, 2012), http://www.washingtonpost.com/national/health-science/parents-insurance-covers-children-up-to-age-26-but-not-for-pregnancy/2012/08/06/2b59f160-6a2c-11e1-acc6-32f6c7ccd67_story.html.

114. *Id.*

115. *Id.*

116. Respect for Rights of Conscience Act of 2011, H.R. 1179, 112th Cong. (2011).

117. Religious Freedom Protection Act, S. 2092, 112th Cong. (2011).

118. Respect for Rights of Conscience Act of 2011, *supra* note 116, at § 3(a)(6)(E); Religious Freedom Protection Act, *supra* note 117, at § 2(d)(3).

119. Respect for Rights of Conscience Act of 2011, *supra* note 116 at § 2(a)(5); Religious Freedom Protection Act, *supra* note 117, at § 2(3).

the care that the supporters of the ACA purport will be available to all females.

The National Partnership for Women and Families has stated, “[w]hile the ACA puts us closer to the day when prevention is a priority and essential women’s health services are covered by all health insurance plans, the [above acts], and similar proposals would undermine the law and dismantle its core protections.”¹²⁰ The organization purports that these acts not only target hot-button issues such as abortion and contraception, but provide the potential for religious employers to refuse to provide a plethora of preventative health services including “maternity care, HIV/AIDS treatment, mammograms, or cancer screenings.”¹²¹ Arguably, for these services to be excluded from a plan the religious provider would have to prove the ways in which the services conflicted with religious or moral beliefs. Further, the Health and Human Services (HHS) amendment provides that to qualify as an exempt religious employer, the employer must be characterized as a “house of worship.”¹²²

Religious employers and affiliates, especially those not characterized as “houses of worship,” are equally worried about narrow exceptions and provisions that may require them to provide services that conflict with their doctrines. The Conference of Catholic Bishops has argued that, while they do not wish for the abolition of the entire ACA, they support the above acts as the “lack of statutory conscience protections . . . forces religious and other employers to cover sterilization and contraception” against the beliefs of the organizations.¹²³ Said religious organizations staunchly advocate against abortion and consider contraception to be “abortifacient.”¹²⁴ Further, religious organizations insist that paying a monetary penalty, while unfair in a basic sense as punishing these institutions for their religious beliefs, also results in the subsidizing of payments for the abortions and contraception.¹²⁵

120. *Access Denied: How Refusal Clauses Hurt Women’s Health*, NAT’L P’SHIP FOR WOMEN & FAMILIES, (Feb. 2012), http://www.nationalpartnership.org/site/DocServer/REPRO_Access_Denied.pdf?docID=9821.

121. *Id.*

122. Chad Brooker, *Making Contraception Easier to Swallow: Background and Religious Challenges to the HHS Rule Mandating Coverage of Contraceptives*, 12 MD. L.J. RACE, RELIGION, GEND. & CLASS 161, 191 (2012).

123. *Bishops Renew Plea to Congress and Administration to Repair Affordable Care Act*, U.S. CONFERENCE OF CATHOLIC BISHOPS (June 28, 2012), <http://www.usccb.org/news/2012/12-119.cfm>.

124. Rebecca Hall, *The Women’s Health Amendment and Religious Freedom: Finding a Sufficient Compromise*, 15 J. HEALTH CARE L. & POL’Y 401, 414–15 (2012) (“Medically speaking, however, hormonal contraceptives cannot cause an abortion, and the belief that such medication is abortifacient is a theological, not medical or legal, contention.”).

125. Jessica Donoghue, *People V. US v. Obama: An Analysis of Religious Challenges to the Patient Protection and Affordable Care Act*, 12 RUTGERS J.L. & RELIGION 202, 214 (2010).

Whether the organizations pay under the shared responsibility plan or whether they pay the penalty, plaintiffs in suits against the provision object that the “payments will ultimately fund abortions.”¹²⁶

The main issue for women regarding these challenges is the impact the challenges will have to women’s access to the services that the ACA provides. The current litigation, and untold future litigation, hinges upon two main questions: first, whether there is a substantial burden upon religious institutions to comply with the ACA, and second, whether the government’s interests are both compelling and narrowly tailored enough to overcome the institutions’ religious freedom under the Religious Freedom and Reformation Act.¹²⁷ There is obvious debate over whether a substantial burden can be found when a provision violates a religion’s sensibilities when the institution is not being asked to endorse or to use the medication.¹²⁸ Even with proof of a substantial burden, a determination will have to be made regarding whether the government’s interest in women’s health is compelling enough to outweigh freedom of religion.¹²⁹ Further, if the religious clauses do result in an excuse for noncompliance, all students’ health insurance may be at risk.¹³⁰

C. The ACA Explicitly Allows States to Pass Laws Allowing Private Insurers Not to Cover Abortion Costs

While the ACA has provided for many necessary services for women, abortion being one of them, state legislatures have been given the detrimental option to ban abortion coverage.¹³¹ In some states this ban reaches only state exchanges: places set up by the state for individuals to choose health insurance. In other states, the ban extends even to private insurers.¹³² For women in these states, this means that “a woman will not be allowed to use her own private money to purchase an exchange-based health plan that covers abortion services, and also may not be able to purchase a plan that provides insurance

126. *Id.*

127. *Id.* at 215.

128. *Id.* at 217.

129. *Id.* at 217–18.

130. *Franciscan University Drops Student Health Insurance Plan over Birth Control Mandate, Costs*, MSNBC: U.S. NEWS BLOG (May 15, 2012, 5:05 PM), http://usnews.nbcnews.com/_news/2012/05/15/11720706-franciscan-university-drops-student-health-insurance-plan-over-birth-control-mandate-costs?lite.

131. *State Bans on Insurance Coverage of Abortion Endanger Women’s Health and Take Health Benefits Away from Women*, NAT’L WOMEN’S LAW CTR. 1, 1–2 (Sept. 13, 2012), http://www.nwlc.org/sites/default/files/pdfs/state_bans_on_abortion_covg_factsheet_9-13-12.pdf.

132. *Id.*

coverage for abortion at all.”¹³³ Further, Louisiana and Tennessee do not permit insurance coverage when the woman needs an abortion because her life is in danger, and seven other states will not provide coverage even if the pregnancy was the result of rape or incest.¹³⁴

To analyze the effects of this provision, it is valuable to consider it concurrently with the first problem addressed in this section with the ACA—the gap that leaves women on their parents’ insurance uncovered for pregnancy.¹³⁵ Thus, a woman’s insurance may fail to cover the costs of her pregnancy and a state may also inhibit insurance to cover the costs of an abortion. While it is not being suggested that a woman would choose abortion simply because she does not have insurance to cover her pregnancy, there are heavy financial burdens that come with covering the medical costs of pregnancy. A delivery alone can cost anywhere between six and eight thousand dollars,¹³⁶ and that figure does not include necessary prenatal care or a complicated pregnancy.¹³⁷ Some state bans on insurance coverage of abortion allow insurance companies to provide a supplemental policy for abortion that the insured must purchase separately.¹³⁸ While supporters of state bans on abortion coverage have touted supplemental insurance as a proper compromise,¹³⁹ women’s advocates state that a supplemental policy is “impractical and undermines the purpose of health insurance.”¹⁴⁰ Further, waiting bills in the state legislatures purport to place restrictions on the availability of a supplemental policy, thus “essentially guaranteeing that it will never exist.”¹⁴¹

D. Undocumented Immigrant Workers

The ACA ignores another large demographic by failing to provide undocumented immigrant workers with neither insurance nor the opportunity to buy it at a higher cost. The Congressional Budget Office has estimated that twenty-three million people in the United States will still be without health insurance after the enactment of the law.¹⁴²

133. *Id.*

134. *Id.*

135. See discussion *supra* Part III.A.

136. *Health Insurance for Pregnant Women*, AM. PREGNANCY ASSOC., <http://www.americanpregnancy.org/planningandpreparing/affordablehealthcare.html> (last visited Nov. 3, 2013).

137. *Id.*

138. *State Bans on Insurance Coverage of Abortion*, *supra* note 131, at 2.

139. *Id.*

140. *Id.*

141. *Id.*

142. Chris McGreal, *US Healthcare Bill Leaves Illegal Immigrants Excluded*, *GUARDIAN* 1, 2 (Mar. 22, 2010), <http://www.guardian.co.uk/world/2010/mar/22/us-healthcare-bill-illegal-immigrants>.

One third of these individuals, a little over seven-and-a-half million, will be undocumented workers.¹⁴³ While historically insurance has never been provided to individuals in this demographic,¹⁴⁴ Texas also excludes people with permanent residence status—individuals who are legally within the country with recognized rights—from buying into the state’s health-care coverage.¹⁴⁵

Ironically, as the ACA is purported to decrease health-care costs across the board, undocumented workers and some permanent residents must visit the emergency room for medical care, which is extremely costly for hospitals.¹⁴⁶ Hospitals are obligated to provide any necessary emergency care to an undocumented worker that they would provide to any citizen and are “precluded from discharging or transferring patients who have not been stabilized.”¹⁴⁷ There is no guarantee that hospitals will be reimbursed for the care that they provide,¹⁴⁸ and if the immigrant has a serious condition, the hospital care is the equivalent of putting a Band-Aid on a gunshot wound. The individual may be discharged from the hospital but require care in a long-term facility that will not admit the person because of his or her failure to pay.¹⁴⁹ This also puts hospitals in a difficult situation because not discharging the individual to a long-term care facility is not an adequate discharge. In some of these cases hospitals are forced to themselves provide the long-term care resulting in an extremely large financial burden.¹⁵⁰

As a result of this large burden, hospitals have engaged in the practice of what advocates for immigrants term as “hospital deportations.”¹⁵¹ This practice is implemented when a hospital cannot find a willing long-term care facility to admit the patient and gains permission from the patient’s country to have the patient returned to the custody of that country.¹⁵² The only case on this topic has been that of Luis Jaminez, but hospital deportation has been exacted on “scores” of immigrants.¹⁵³ The hospital in the *Jaminez* case argued that they

143. *Id.* at 2.

144. *Id.* at 1.

145. *Id.* at 2.

146. Janet L. Dolgin & Katherine R. Dieterich, *When Others Get Too Close: Immigrants, Class, and the Health Care Debate*, 19 CORNELL J.L. & PUB. POL’Y 283, 286–87 (2010).

147. *Id.* at 286.

148. *Id.* at 287.

149. *Id.* at 288.

150. *Id.*

151. *Id.* at 293.

152. Dolgin & Dieterich, *supra* note 146, at 293–94.

153. *Id.* at 293, 288–89. Jaminez received 1.5 million dollars worth of care over a period of four years from Martin Memorial Hospital in Florida after suffering extreme brain trauma in a car accident.

had provided maximum medical care to the patient and that it was now appropriate for Jaminez to be transferred back to his home country.¹⁵⁴ The hospitals frame these returns as assistances with repatriations instead of deportations with removals,¹⁵⁵ but advocates point out deportation is a harsh consequence for individuals providing a cheap source of labor for the American economy, who are not even permitted to pay to have a minimal amount of insurance coverage.¹⁵⁶

Advocates of the ACA have unapologetically declared that the reason for limiting health-care provisions to undocumented workers is because public opposition would have been so widespread that it would have undermined the entire health bill.¹⁵⁷ Public opposition is purportedly linked to a worry that middle- and lower-class citizens would have to compete with immigrants for health-care resources.¹⁵⁸ Whether this would truly have stopped the bill in its tracks is debatable. What is not debatable, however, is that there is a sizeable population in the United States that is devoid of health insurance and as the law stands, is incapable of ever getting it.

Within this sizeable population, it is obvious that one will find women without health insurance for even the most basic services, not to mention the new preventative service measures put in place by the ACA. Without extensively examining the Supreme Court's views of the rights of the immigration population under the Constitution, from the time mass immigration began in the United States to the present day, the Court has recognized a plenary power in the Congress over any matter having to do with immigration.¹⁵⁹ It has also been recognized, however, that Congress' power may be limited—and the Court's power may be expanded—in dealing with undocumented immigrants outside the spheres of immigration and not involving national security or international affairs.¹⁶⁰

Yet, Congress has chosen to expressly deny insurance coverage to undocumented workers under the ACA.¹⁶¹ While it is possible that

154. *Id.* at 289–90.

155. *Id.* at 295.

156. *Id.* at 297.

157. *Id.* at 313.

158. Dolgin & Dietrich, *supra* note 146, at 314.

159. Roy G. Spece, Jr., *Constitutional Attacks Against the Patient Protection and Affordable Care Act's "Mandating" that Certain Individuals and Employers Purchase Insurance while Restricting Purchase by Undocumented Immigrants and Women Seeking Abortion Coverage*, 38 N. KY. L. REV. 489, 531–32 (2011).

160. *Id.* at 533.

161. ALISON SISKIN, CONG. RESEARCH SERV., TREATMENT OF NONCITIZENS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 10 (2011), available at <http://www.nafsa.org/uploadedFiles/CRS%20analysis%20re%20noncitizens.pdf>.

this lack of provision creates a constitutional problem,¹⁶² it also creates a practical problem as discussed above. The ACA purports to decrease costs both for individuals and for the insurance market.¹⁶³ Individuals will be covered and hospitals and other care providers will not have to absorb costs for individuals who are not insured. In turn, they will not have to increase costs for those who are insured. This will not work, however, if individuals are consuming health care but do not have insurance, and for whom it is not feasible to have insurance.

While denying health care to undocumented immigrants in general provides a debatable question of constitutionality, denying health care to women who are undocumented immigrants tips the scales even more in favor of unconstitutionality. These women belong to two quasi-suspect classes, as aliens and as women,¹⁶⁴ and it is conceivable that a right to health care is fundamental.¹⁶⁵ As Spece has noted, however, the government's interests in denying immigrants health care likely does not have to be specifically noted and may involve legitimate concerns such as "preserving medical resources for legal residents . . . protecting societal integrity, [and] garnering political support."¹⁶⁶ Thus it appears that aside from state legislation denials, religious exceptions, and lack of coverage for certain health needs, undocumented immigrants face a huge dilemma in accessing not just adequate health care but any health care at all.

E. The Negative Impact of the ACA on Seniors

While the ACA has been purported to provide a number of benefits to senior women, including preventative screenings for breast cancer and bone density tests to prevent osteoporosis,¹⁶⁷ a debate exists over whether the Medicare expansions will decrease the costs and the quality of health care for older women or lead to an increase.¹⁶⁸ The

162. Spece, *supra* note 159, at 529–31 (discussing immigrants as a quasi-suspect class requiring a higher degree of scrutiny for governmental deprivation of basic rights).

163. *Id.* at 493.

164. See *United States v. Virginia*, 518 U.S. 513, 515 (1996) (applying an intermediate level of scrutiny to Virginia Military Institute's ("VMI") policy and holding that VMI had violated the Fourteenth Amendment by excluding women from its school without providing an "exceedingly persuasive justification" for doing so); *Graham v. Richardson*, 403 U.S. 364, 375 (1971) (applying a rational basis "plus" level of scrutiny and holding that provisions of state welfare laws that conditioned benefits upon citizenship were unconstitutional).

165. *Virginia*, 518 U.S. at 540–44; see also *Washington v. Glucksberg*, 521 U.S. 702, 720–21 (1997); *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 278–79 (1990).

166. Spece, *supra* note 159, at 577.

167. Pollitt, *supra* note 66, at 4.

168. See HEALTHCARE AND YOU: THE HEALTHCARE LAW AND MEDICARE, AARP 1, 4 (2012), available at http://www.aarp.org/content/dam/aarp/health/healthcare_reform/2012

fear for elderly individuals on Medicare is that under the new law with the cuts to Medicare, Medicare will pay less to doctors and hospitals, thereby forcing these hospitals and doctors to drop patients or to refuse to accept patients who have Medicare.¹⁶⁹ While the Senate bill for the ACA states that the federal government will pay doctors and hospitals that report quality performance in “common, high-cost conditions,”¹⁷⁰ there is a concern that the funds will not exist to do so given Medicare cuts.¹⁷¹

Proponents of the assertion that the ACA will decrease costs concede that seniors must use the pre-approved services provided by Medicare;¹⁷² further, the law does not allow seniors to “top up” their benefits to pay the difference for which Medicare will not provide.¹⁷³ Even if seniors were permitted to pay out of pocket, it has been estimated that by 2017 that would require ten percent of their Social Security check and fifty years from now, if Medicare spending continues to decline, that it would require half of one’s Social Security check.¹⁷⁴ This would have an especially profound effect on older women, who it is estimated consume more health care resources in their later years.¹⁷⁵

A harder impacted group includes those women who are low-income and “near-elderly.”¹⁷⁶ These women include those in the age group of fifty-five- to sixty-four-year-olds.¹⁷⁷ When approving the ACA, the Court refused to allow the federal government to mandate Medicaid expansion in the fifty states.¹⁷⁸ As a result, women in this age group who may not be covered by a spouse for reasons of divorce, widowhood, or unemployment are more likely not to be covered by

-08/health-law-and-medicare-brochure-aarp.pdf (arguing that spending cuts in some areas of health care will go to benefit seniors by cutting costs of prescription drug coverage and providing money to institutions providing more quality care); *but see* THOMAS R. SAVING, NAT’L CTR FOR POL’Y ANALYSIS, HOW WILL THE AFFORDABLE CARE ACT AFFECT THE ELDERLY AND DISABLED ON MEDICARE? 1, 2 (2010), *available at* <http://www.ncpa.org/pdfs/NCPA-Social-Security-Trustees-Briefing-2010.pdf> (cautioning that spending cuts to Medicare are likely to decrease the quality of care to seniors).

169. SAVING, *supra* note 168, at 2.

170. DEMOCRATIC POL’Y AND COMM. CTR., PATIENT PROTECTION AND AFFORDABLE CARE ACT: DETAILED SUMMARY 4, *available at* <http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf> (last visited Nov. 3, 2013).

171. SAVING, *supra* note 168, at 2.

172. HEALTHCARE AND YOU, *supra* note 168, at 5.

173. SAVING, *supra* note 168, at 2.

174. *Id.*

175. Greenberger & Codisoti, *supra* note 4, at 7.

176. Dinah Wisenberg Brin, *Near-Elderly Women and a New Medicaid Disparity: Many Will Be Left Out As States Thwart Program Expansions*, LDI HEALTH ECON. 1, 1 (June 2012), <http://ldihealtheconomist.com/he000033.shtml>.

177. *Id.*

178. *Id.*

private insurance and will not be able to receive Medicaid benefits.¹⁷⁹ The women in this group do not qualify for Medicare until the age of sixty-four and thus find themselves in a demographic that has no affordable health insurance despite the many provisions for women in the ACA.¹⁸⁰

What makes these uninsured women more vulnerable than younger women without insurance is that near-elderly women are more susceptible to illness as “they have a higher likelihood of pre-existing conditions, they’re at a heightened risk for all types of cancers, they’re becoming more frail and less mobile, and they don’t get preventive care.”¹⁸¹ Further, once these women do reach an age at which they may receive Medicare benefits, they are more costly to take care of.¹⁸² This will only enhance the problem discussed above regarding reductions in Medicare resources.¹⁸³

It has been estimated by former senior White House economist Mark Duggan that 3.7 million women in this age bracket are uninsured.¹⁸⁴ If the states would agree to expand Medicare, 1.2 million of these women would be eligible for benefits and another 1.8 million would be eligible for insurance exchange subsidies.¹⁸⁵ If the Medicaid expansion program were executed in all fifty states, it would decrease the number of near-elderly women who were uninsured to two percent of all near-elderly women.¹⁸⁶ Aside from the Medicaid expansion, the ACA originally intended to expand coverage for near-elderly women including eliminating age, gender, and pre-existing condition discrimination.¹⁸⁷ While benefits have been extended to younger women, especially in the realm of reproductive health, there has been a disproportionate effect on these older women who arguably need preventative and affordable benefits just as much, if not more, than younger women.

IV. ACCESS TO HEALTH CARE, BUT NOT CHOICE

In 2003, Ted Kennedy acknowledged the growing crisis in health care as one of an outright lack of care for individuals without insurance: “[h]ealth care is not just another commodity. It is not a gift to be rationed based on the ability to pay. It is time to make universal

179. *Id.* at 2.

180. *Id.*

181. Brin, *supra* note 176, at 2–3.

182. *Id.* at 2.

183. See discussion *supra* Part III.E.

184. Brin, *supra* note 176, at 3.

185. *Id.*

186. *Id.* (including undocumented immigrant women in this figure).

187. *Id.*

health insurance a national priority, so that the basic right to health-care can finally become a reality for every American.”¹⁸⁸

While the continuing initiative to provide Americans with said health care is an admirable one, it may be that the ACA, and indeed any health-care plan that gives power to the government to regulate what health-care services are available to individuals, may also be a dangerous goal, especially given the possible effect on women’s choice.

Instead of rationing health care based upon the ability to pay, it seems that health care will be rationed based upon whose ideology and belief is most favored by those who are distributing health care.¹⁸⁹ Aside from the constitutionality arguments made on both sides involving the Commerce Clause, the Tax Power, and the Necessary and Proper Clause, the right of choice that opponents of the ACA assert are particularly relevant to women.¹⁹⁰ This choice involves the voluntary engagement in a particular health-care program that opponents agree the government is permitted to regulate.¹⁹¹ The opposition has argued, however, that the government is not permitted to regulate inactivity or to tax people as a penalty for not engaging in an activity.¹⁹²

In the context of women’s rights, certain groups of women will be forced to choose a health-care plan that limits their access to certain care and may forbid certain services altogether. If women choose not to have their rights limited in this way, they will be taxed *and* they still may not receive health care that has been deemed by some to be a “basic right.”¹⁹³ On the other hand, because of their status as non-citizens, some women will be denied even the choice to be taxed or to receive regulated services.

None of these “options” appear to be choices at all but rather choosing the lesser evil or complete denial of coverage. These negative alternatives appear to have been overlooked given the acclamation

188. Edward M. Kennedy, *Quality, Affordable Health Care for All Americans*, 93 AM. J. PUB. HEALTH 1, 14 (2003) (recognizing the health crisis and “[l]ack of insurance [that] creates a tragic burden of unnecessary disease, early death, and financial devastation.”).

189. Ilya Somin, *A Mandate for Mandates: Is the Individual Health Insurance Case a Slippery Slope?*, 75 LAW & CONTEMP. PROBS. 75, 79–98 (2012) (highlighting the “slippery slope” arguments advanced by opponents of the ACA).

190. *Id.* at 100–01 (stating that in determining the constitutionality of the mandate the Eleventh Circuit ultimately held that “[i]ndividuals subjected to this economic mandate have not made a voluntary choice to enter the stream of commerce, but instead are having that choice imposed upon them by the federal government.”) (citing *Florida ex rel. Atty. Gen. v. U.S. Dept. of Health & Human Services*, 648 F.3d 1235, 1291–92 (11th Cir. 2011) (*aff’d* in part, *rev’d* in part *sub nom.* Nat’l Fed’n of Indep. Bus. v. *Sebelius*, 132 St. Ct. 2566, 2609 (2012))).

191. *Id.* at 101.

192. *Id.* at 87–88.

193. *See supra* note 165 and accompanying text.

that many women's groups have expressed in response to the passage and upholding of the ACA.¹⁹⁴

As doctor John Geyman has noted, “[t]he ACA’s fundamental flaw is that it props up an inefficient and exploitative private health insurance industry while not recognizing that deregulated markets can’t fix systemic problems of access, costs, quality, equity, accountability and sustainability.”¹⁹⁵ Relevant to women, the problems of access, equity, and accountability appear to be those that the ACA, though it may try, cannot regulate through this legislation.

Steven Ney provides insight into why, despite valorous efforts to provide adequate health care to a marginalized population such as women, it may be impossible on a national level and indeed may require action on a global scale.¹⁹⁶ While this note has focused narrowly on the implementation of the ACA, a global perspective may provide insight into the flaws of the ACA, the obstacles that women face in having their right to access equitable health care, and how these obstacles may be overcome.

This is not to say that if it is determined that overall the ACA does fail women that a global campaign for health care is required. Instead, it may serve to elucidate the flaws of the system and to develop a more equitable system for everyone, women included. For instance, Ney advocates that the system we currently operate under “is beyond technocratic fixes or market Utopias.”¹⁹⁷ Instead he and other health rights advocates believe that “[w]hat we need—quickly—is fundamental changes to our institutions and our lifestyles.”¹⁹⁸ Ney posits that in a developed country such as our own, the focus should be on providing “high-quality health care in the face of growing social and demographic change.”¹⁹⁹

It is not suggested that the ACA does not try to accomplish this. Indeed, it has been made very clear that one of the large objectives of the legislation is to provide women with more voice and more choice

194. See, e.g., *Passage of the Historic Health Care Reform Law is a Huge Step Forward for Women*, NAT'L P'SHIP FOR WOMEN & FAMILIES, http://go.nationalpartnership.org/site/PageServer?pagename=issues_health (last visited Nov. 3, 2013). But see Cindy Pearson, *Where There's a Will, There's a Way!*, NAT'L WOMEN'S HEALTH NETWORK (Feb. 1, 2013), <http://nwhn.org/2013/02/01/where-there%E2%80%99s-will-there%E2%80%99s-way> (recognizing that there are still flaws in the system but that the act is a step in the right direction for women's health).

195. John Geyman, *The Affordable Care Act: What to Expect in 2013*, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM (Jan. 24, 2013), <http://www.pnhp.org/news/2013/january/the-affordable-care-act-what-to-expect-in-2013>.

196. Steven Ney, *Making Sense of the Global Health Crisis: Policy Narratives, Conflict, and Global Health Governance*, 37 J. HEALTH POL. POL'Y & L. 253, 253 (2012).

197. *Id.* at 265.

198. *Id.*

199. *Id.* at 268.

in their health-care decisions.²⁰⁰ Given all of the limitations discussed in Section III, however, it is evident that this is a law that neither fully protects a woman's right to health care nor her choice of what health care she wishes to receive. While provision of preventative services and some cost-management strategies have been promised, this promise extends only to some and is still attenuated on many factors outside of the individual's control.

Dr. Geyman espouses multiple steps that may improve the current state of health care for everyone—two of which are particularly relevant to protecting women's rights.²⁰¹ The first of these is to expose, at community, state, and federal levels, any abuses or cruelty related to the provision, or nonprovision of health care that is an obvious denial of the rights that the ACA is meant to protect.²⁰² The second is to advocate for more comprehensive oversight by the government of the health-care system to be based in actual scientific research on coverage and cost-effectiveness issues instead of allowing lobbyists with deep pockets and loud voices to dictate what they think is best.²⁰³

CONCLUSION

Politics, religion, and policy are all at play in the health-care debate. An agreement on exactly what should or must be provided will never be reached on all sides, and every group or individual's fundamental disagreement is impossible to compromise. This is not an excuse, however, to deny women the right to make their own choices, especially under a health-care act that champions its advocacy for the rights of women.

The ACA is a commendable start to improving women's health care, but until all states are required to give women the services they are guaranteed under the act, until health-care costs are truly contained for all women, until religious institutions are forced to respect the rights of women to make their own health-care choices, and until equal access is given to all women, no one can say that the battle to advance and to protect women's health has been won.

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200. JARRETT & TCHEN, *supra* note 64, at 12–17.

201. Geyman, *supra* note 195.

202. *Id.*

203. *Id.*

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