Plenary Panel - The Social Safety Net (or Lack Thereof)
Health Care Reform and (In)Equality in Women's Health Care

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Medicaid covers half of all births and two-thirds of all unintended pregnancies in the United States. Unintended births are five times more likely to occur for impoverished women. Women are more likely to live in poverty than men, especially as they become elderly. And, women live longer than men on average, which means over their lifetime they are likely to need more medical care. They are also more likely to need long term care, for which Medicaid is the primary payor.

These numbers highlight both successes and failures in the American safety net. On one hand, pregnant women have been able to access consistent health care, necessary for the wellbeing of both the woman (during and after pregnancy) and her child, through Medicaid's program of medical assistance. On the other hand, Medicaid has reinforced the policy of exclusion in governmental assistance by limiting its reach to the "deserving poor" – impoverished parents, children, elderly, and disabled individuals – for its first forty-nine years. Further, women's reliance on Medicaid underscores the high rates of poverty for women and children in the United States as well as the close link between economic status and health status.

I will explore the successes and challenges that health care reform has posed for women's health care given the ongoing societal, political, and economic challenges that women face. The Affordable Care Act directly addressed inequalities in women's health by targeting their needs through requirements such as coverage of maternity care and the prohibition on sex discrimination in premium rate setting. The ACA also indirectly benefits women's health with provisions that facilitate greater insurance coverage for all, such as expansion of dependent coverage to age 26. But, women still face barriers to health equality, barriers that weaken the safety net.

Some of these barriers are the result of ongoing broad-based societal challenges; health care reform addresses these challenges (to a degree) by helping to ensure that women are healthy members of the polity, benefiting them in their personal and work spheres. Some barriers result from challenges to the ACA that impact large portions of the population. For example, *NFIB v. Sebelius* enabled states to opt out of Medicaid expansion, and in states that have not yet expanded, a coverage gap exists for people who are too poor to receive a premium assistance tax credit but who do not qualify for Medicaid. At least four million people fall into the coverage gap, and half of the individuals in that gap are women. Another example is the Supreme Court's consideration of the meaning of exchanges "established by the state" in *King v. Burwell.* If the Court holds that the ACA does not allow for tax credit assistance in federally-run exchanges, then an estimated thirteen million people will find that health insurance is unaffordable, half of which are women. Challenges to the ACA's contraception coverage requirements also erode women's access to needed medicine.

These broad barriers exist alongside a more pointed problem – namely, that women's health care is traded for other political or policy gain. For example, when the ACA was drafted, the most common surgical procedure for women was excluded from its broad coverage umbrella - abortion. Women's health care was also traded when the Obama Administration allowed states to forbid coverage of abortion in the exchanges, expanding the

Hyde Amendment's funding limitation to private insurance. The recent negotiations over ending the Medicare 'doc fix' offer another example. Folded into the legislation was continued extension of the Hyde Amendment to community health centers, upon which many poor women rely for their reproductive and other health care. Such horse trades are occurring on federal and state levels.

Health care reform embraced a principle of universality, attempting to ensure that all Americans were able to be covered by and able to afford health insurance. But, treating women's health care as a device for negotiation jeopardizes the gains in equality and strengthening of the safety net that the ACA could otherwise facilitate.