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The New Health Care Law: How Will Women Near Retirement Fare?

Kate C. Prickett, MP Aff [a,*], Jacqueline L. Angel, PhD [b]

[a] Department of Sociology & Population Research Center, University of Texas at Austin, Austin, Texas
[b] LBJ School of Public Affairs, Department of Sociology & Population Research Center, University of Texas at Austin, Austin, Texas

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A B S T R A C T

Background: In 2009, more than 17 million women lacked health insurance coverage in the United States. A disproportionate number of these women were African American or Latino. In addition, many women aged 55 to 64 lack coverage through either their own employment or access to a spouse's plan at a time when they face an elevated risk of long-term and life-threatening illness. The study's objective is to understand the extent to which the Patient Protection and Affordable Care Act, signed in March 2010, will increase coverage for pre-retirement age women through the new health insurance exchanges and the expanded Medicaid program.
Methods: This study employs the 2009 American Community Survey to compare health insurance coverage among aging women by race and ethnicity.
Results: The results reveal that the new health care law could reduce the number of uninsured pre-retirement age women from 11.7% to 1.9%. However, it is unlikely that all women with the opportunity to access health insurance coverage will do so. In addition, despite the potential increase in access, Mexican-American women are still overrepresented among the uninsured, representing 5.7% of the total uninsured while only comprising 3.3% of all pre-retirement age women.
Conclusion: The research has important implications for how numerous provisions enacted in the new health care law will reduce the number of uninsured adults, particularly vulnerable women. These findings make it clear that Medicaid expansion and insurance exchanges will vary across states, and consequently will have potential benefits in particular for low-income minority group women.

Introduction and Background

The Patient Protection and Affordable Care (PPAC) Act, signed into law by President Obama on March 23, 2010, promises to curtail growing health care costs, expand coverage to the underinsured and uninsured, and improve efficiencies in the delivery of health care services. This landmark health care reform legislation will help to ensure that all Americans have access to affordable health care, particularly those individuals who currently lack health insurance and those who pay high premiums. More specifically, the Act will help make coverage affordable to many uninsured Americans, including low-income people, the working poor, workers who are not offered employer-sponsored insurance, and eligible individuals who have a preexisting health condition or who previously had significant health problems (Blumberg, 2010).

Included among these groups set to benefit from health care reform are women in general, who are less likely than men to have coverage through their own employment or a lack of access to a spouse's employer-sponsored health insurance plan (Kaiser Family Foundation, 2009b). These two factors—marriage and employment—can lead to greater insurance instability for women. Historically institutionalized gender roles have created a system that places women at a disadvantage relative to men in terms of their access to employer-based health benefits, because men have traditionally been the primary economic provider in marriage (Harrington Meyer & Herd, 2001). For example, it is estimated that more than 1 million women lost health insurance because of a spouse's job loss during the first year of the current recession (Majority Staff of the Joint Economic Committee, 2009). Experts also note that disadvantages in employment and the traditional male bread-winner model create unique

* Correspondence to: Kate C. Prickett, MP Aff, Department of Sociology & Population Research Center, University of Texas at Austin, 2505 University Avenue, Austin, TX 78712. Phone: (512) 471-5514; fax: (512) 471-1748.
E-mail address: kate.prickett@mail.utexas.edu (K.C. Prickett).

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vulnerabilities for minority group women who have weaker ties to these institutions (Bird & Reiker, 2008).

Pre-Retirement Age Women and Health Insurance

Approximately 15% of adult women (or 17 million women) in the United States were without coverage in 2009. The gap in coverage is particularly severe for women approaching retirement age (55–64 years). Among all pre-retirement age people, women are less likely than men to have coverage from a current job (33.2% vs. 40%, respectively; Vistnes, Cooper, Bernard, & Banthin, 2009). About 1 out of 10 married women 50 to 70 years old each year lose coverage because their older spouse's retirement results in a loss of employer-sponsored coverage (Lambrew, 2008). In addition to their spouse's retirement, pre-retirement age women (and women, generally) are also at risk of losing insurance through their partner's death or other marital disruption (Lavelle & Smock, 2010; Weir & Willis, 2003), a time in life when serious health problems become common. Women in this age range face a seriously elevated risk of long-term and life-threatening illness, as well as a loss of productivity and an increase in dependency (Brennan, 2000; McWilliams, Zaslavsky, Meara, & Ayanian, 2004; Mutschler, 2001; Xu, Patel, Vahratian, & Ransom, 2006). This same susceptibility, in turn, may result in higher premiums for health insurance products, making private coverage unaffordable for many older women (Patchias & Waxman 2007). The consequences of being without coverage among pre-retirement age women are serious and have been linked with a decrease in health service use (Xu et al., 2006).

Although prior research has highlighted that the pre-retirement age can be a significant period of insurance instability for women, scant research has elaborated on how influential the current health care reforms may be in protecting these women from health insurance loss or helping them to become insured during this period (Angel, Montez, & Angel, 2010). The enactment of the new health care law (PPAC Act) promises to improve the situation of a substantial number of these women. If the law is implemented as written, many minority women who are currently uninsured will be able to purchase subsidized coverage though the new health insurance exchanges, and the poorest will qualify for Medicaid, which in 2014 will be extended to all adults in households with incomes below 133% of the Federal Poverty Line (FPL).

To understand the potential benefits of the new law for pre-retirement age women and for minorities in particular, the present study compares health insurance coverage among African-American, Mexican-American, and non-Hispanic White women in this age range in 2009. To this end, these best-case analyses estimate the number of these women who will have access to health insurance through the expanded Medicaid program and the Health Insurance Exchanges. Second, we discuss how existing state-level variation in Medicaid eligibility rules and state demographic characteristics affect the rates of uninsured women who will be newly eligible, the role of the Individual Mandate and standardization of enrollment procedures in influencing program participation, and other regulations to be implemented under the PPAC Act that will bring down the cost of health insurance for women in general, including pre-retirement age women. The ultimate goal is to offer policy recommendations for pre-retirement age women, especially immigrants who, based on the following analyses, will continue to be overrepresented in the underinsured and uninsured pre-retirement age population after the new health care law is implemented.

Health Reform: Medicaid Expansion and Health Insurance Exchange Credits

Many of these currently underinsured and uninsured pre-retirement age women are set to benefit from health insurance initiatives as part of the new health reform law. Part of the PPAC Act will expand the public health insurance program, Medicaid, to those individuals and families living at or below 133% of the FPL. Currently, Medicaid eligibility differs by state, with 34 states setting eligibility levels below 100% of the FPL and 17 of those states setting levels below 50% of the FPL (Kaiser Family Foundation, 2009a). In addition, Medicaid will now be available to all individuals and families, not just the disabled and parents. Currently, only five states offer Medicaid to nondisabled, childless adults. Undocumented immigrants and legal residents who have not been in the United States for at least 5 years are ineligible (Kaiser Family Foundation, 2010).

In addition to an expanded Medicaid program, the law mandates the creation of state and/or regional health insurance exchanges (i.e., Exchanges) where individuals and families can purchase private insurance. Individuals and families living between 100% and 400% of the FPL are eligible to receive premium credits and cost-sharing subsidies, which subsidize the cost of insurance premiums and out-of-pocket health care costs. Individuals and families are granted premium credits based on their income and the cost of the premium, with lower income persons receiving larger subsidies than higher income persons. Undocumented immigrants are prohibited from purchasing insurance through the state (or regional) exchanges, but legal residents, no matter how long they have been living in the United States, are eligible to participate in the Exchanges and receive premiums and subsidies (Kaiser Family Foundation, 2010).

What follows next is a description of methods to determine 1) the relative fraction of pre-retirement age women in various race and ethnic groups who would qualify for Medicaid under the new eligibility criteria, 2) how the newly eligible rates vary across states, and 3) who would still be left with limited health insurance access after implementation of the health reform law.

Methods

Data

The data for this study come from the 2009 American Community Survey, an annual survey of a nationally representative sample of household members in the United States. The American Community Survey includes more than 3 million respondents, with information on family characteristics, income, housing, utility expenses, and health insurance coverage (U.S. Census Bureau, 2009). The large sample size allows us to derive state-level estimates and to disaggregate the analyses by race/ethnic. The study group consists of 209,544 women aged 55 through 64 at time of interview in 2009, including 162,596 non-Hispanic Whites, 19,809 African Americans, 6,030 Mexican Americans, and 4,428 other Hispanics.

Measures

Independent variable

Age is determined through a continuous variable which identifies the respondents' age at the time of the interview. Race and ethnicity variables are constructed through multiple dummy and categorical questions that respondents were asked in identifying their race and ethnicity. Primarily, our study identifies non-Hispanic Whites, African Americans, Mexican Americans, and other Hispanics.

Dependent variable

Health insurance coverage was identified by answers to the question "Is this person CURRENTLY covered by any of the following types of health insurance or health coverage plans?" (U.S. Census Bureau, 2010). As a result, type of health insurance coverage is not a mutually exclusive category. The primary sources of health insurance for pre-retirement age women were private employer-based insurance and Medicaid, the insurance market most likely to expand coverage to this group as part of the new health reform law. Thus, in the analysis that follows, our primary focus encompasses both of these insurance types. Health Insurance coverage type "other" includes those respondents who indicated that they were covered by Medicare (which typically is not available to women until they reach 65 years of age), active military or veterans' health insurance (TRICARE), or those women receiving care through the Indian Health Service.

Newly Eligible Health Insurance Estimates

The newly eligible health insurance estimates presented herein reflect those women who were between 55 and 64 years old in 2009 and who would have become eligible for Medicaid and premium credits and cost-sharing subsidies if the law had been implemented in 2009. Many of the changes, however, will not be enacted until 2014. The health insurance estimates also partially take into consideration immigration status qualifications related to the Medicaid expansion and Exchanges. For example, only legal immigrants are eligible to participate in Medicaid or receive premium credits and cost-sharing subsidies. In addition, legal immigrants are barred from participating in Medicaid until they have been in the United States for 5 years (Kaiser Family Foundation, 2010). The estimates presented herein reflect these qualifications, which means legal immigrants who have moved to the United States within the past 5 years and who live at or below 133% of the FPL will be reflected in the number of women newly eligible for premium credits and cost-sharing subsidies, but not in the number of those eligible for the Medicaid program. Finally, a minute proportion of the sample (0.5%) did not have data on household income and so were not included in our newly eligible estimates.

Results

Newly Eligible Pre-Retirement Age Women

Table 1 presents the total number of women aged 55 to 64 who currently have no health insurance coverage, and who would now be eligible (or previously did have access to Medicaid but were not participating in the program) to either participate in the Medicaid program or receive premium credits to use in the Exchanges. Overall, there were more than 2 million pre-retirement aged women without any health insurance coverage, 11.7% of this population. Of those women, 33.2% would now be eligible for the expanded Medicaid program and a further 50.7% would be eligible to receive premium credits to help purchase health insurance in the Exchanges. In total, this accounts almost 84% of all pre-retirement age women who are currently uninsured (or 1.8 million women). Despite high existing participation rates in Medicaid by African-American pre-retirement age women, African-American women with no existing health insurance coverage are set to benefit the most from the Medicaid program expansion. Meanwhile, Mexican-American and other Hispanic pre-retirement age women are set to benefit marginally better than non-Hispanic White and African-American women from the premium credits and cost-sharing subsidies to be used in the Exchange (53.8% and 54% vs. 51.2% and 46.1%, respectively).

Table 1
Newly Eligible Women Aged 55 to 64 Years Old with No Current Health Insurance

	Total Sample (*n*)	No Insurance		Newly Eligible			
				Medicaid		Premium Credits	
		n	%	*n*	%	*n*	%
Non-Hispanic White	13,445,866	1,192,814	8.9	385,289	32.4	608,624	51.2
African American	1,951,759	297,539	15.2	122,890	41.5	136,539	46.1
Mexican American	596,570	188,838	31.7	67,526	35.8	101,494	53.8
Other Hispanic	446,983	114,102	25.5	31,684	27.8	61,549	54.0
Total	18,036,823	2,117,929	11.7	701,910	33.2	1,069,846	50.7

Note: Both numbers and percentages are weighted. Data Source: 2009 American Community Survey.

Newly Eligible Pre-Retirement Age Women by State

Table 2 displays the number of pre-retirement age women in each state who had no current health insurance and who would or would not be eligible to participate in the Medicaid program and receive premium credits and cost-sharing subsidies. As expected, states that have implemented their own universal health care systems or with already high Medicaid eligibility rates had some of the highest insurance rates among pre-retirement age women (such as Massachusetts, where only 2.5% of these women lack coverage). States that currently set Medicaid at the federal minimum income eligibility levels and offer participation only to children, pregnant women, parents, disabled persons, and some elderly (groups targeted by the federal government) are most likely to experience greater Medicaid access rates for their uninsured. The states with the highest number of uninsured pre-retirement age women who would be eligible for Medicaid under the PPAC Act are North Dakota, Alabama, and Iowa (47.7%, 45.6%, and 44.4% of uninsured pre-retirement age women, respectively). All three states have income eligibility thresholds below poverty (ranging from 24% through 83% of the FPL), in addition to not accepting childless adults into their Medicaid programs. This eligibility criterion is particularly important for women close to retirement, who are much less likely than the general population to have children in the household (12% of pre-retirement age women compared with 53.8% of their younger counterparts). In fact, states that do already offer Medicaid coverage to childless adults have some of the lowest newly eligible rates for pre-retirement age women of all states. These states are Delaware (51st of 50 states plus the

Table 2
Newly Eligible Women Aged 55 to 64 Years Old with No Current Health Insurance by State

	Total Sample (*n*)	No Insurance		Newly Eligible			
				Medicaid		Subsidy Program	
		n	%	*n*	%	*n*	%
Alabama	291,923	31,017	10.6	14,152	45.6	13,734	44.3
Alaska	37,366	3,360	9.0	662	19.7	1,853	55.1
Arizona	366,807	49,055	13.4	15,590	31.8	25,207	51.4
Arkansas	176,031	23,598	13.4	9,400	39.8	11,715	49.6
California	1,977,233	294,585	14.9	83,831	28.5	150,115	51.0
Colorado	287,617	31,497	11.0	8,878	28.2	16,123	51.2
Connecticut	217,846	15,543	7.1	3,989	25.7	8,301	53.4
Delaware	56,057	4,817	8.6	565	11.7	3,115	64.7
District of Columbia	36,886	3,383	9.2	968	28.6	1,701	50.3
Florida	1,147,550	194,992	17.0	60,709	31.1	100,962	51.8
Georgia	544,049	75,389	13.9	27,160	36.0	36,603	48.6
Hawaii	78,603	4,313	5.5	1,014	23.5	1,825	42.3
Idaho	87,984	9,664	11.0	3,067	31.7	5,291	54.7
Illinois	732,722	92,341	12.6	27,587	29.9	48,483	52.5
Indiana	377,622	37,209	9.9	11,668	31.4	21,165	56.9
Iowa	179,053	8,906	5.0	3,952	44.4	3,752	42.1
Kansas	159,575	12,362	7.7	4,281	34.6	6,110	49.4
Kentucky	265,201	31,184	11.8	13,261	42.5	15,979	51.2
Louisiana	266,860	42,652	16.0	17,154	40.2	21,189	49.7
Maine	92,710	8,557	9.2	2,137	25.0	5,421	63.4
Maryland	351,682	30,301	8.6	7,487	24.7	13,941	46.0
Massachusetts	405,496	11,387	2.8	2,683	23.6	5,557	48.8
Michigan	622,207	61,081	9.8	25,773	42.2	27,339	44.8
Minnesota	307,592	19,033	6.2	6,110	32.1	9,898	52.0
Mississippi	170,256	22,506	13.2	9,851	43.8	10,402	46.2
Missouri	362,841	35,790	9.9	14,187	39.6	16,257	45.4
Montana	63,192	8,594	13.6	2,818	32.8	5,282	61.5
Nebraska	100,923	8,290	8.2	2,829	34.1	4,522	54.5
Nevada	148,350	25,017	16.9	6,885	27.5	13,761	55.0
New Hampshire	85,192	8,046	9.4	2,876	35.7	3,238	40.2
New Jersey	527,515	56,919	10.8	14,088	24.8	26,694	46.9
New Mexico	120,995	17,216	14.2	6,841	39.7	9,101	52.9
New York	1,200,271	87,432	7.3	24,242	27.7	42,704	48.8
North Carolina	567,058	71,005	12.5	24,588	34.6	37,361	52.6
North Dakota	36,412	2,850	7.8	1,360	47.7	1,174	41.2
Ohio	716,732	77,479	10.8	29,872	38.6	39,037	50.4
Oklahoma	216,421	28,500	13.2	11,236	39.4	13,403	47.0
Oregon	253,628	35,773	14.1	11,806	33.0	18,900	52.8
Pennsylvania	799,234	58,733	7.3	20,334	34.6	31,081	52.9
Rhode Island	65,809	7,134	10.8	1,986	27.8	3,673	51.5
South Carolina	293,496	39,486	13.5	15,151	38.4	19,488	49.4
South Dakota	48,914	5,827	11.9	1,378	23.6	4,034	69.2
Tennessee	395,503	52,566	13.3	21,663	41.2	24,176	46.0
Texas	1,256,057	233,449	18.6	82,802	35.5	116,177	49.8
Utah	119,202	14,478	12.1	4,528	31.3	7,731	53.4
Vermont	43,047	1,827	4.2	356	19.5	1,233	67.5
Virginia	468,859	39,893	8.5	11,215	28.1	21,750	54.5
Washington	412,831	39,208	9.5	11,833	30.2	19,523	49.8
West Virginia	125,689	16,339	13.0	6,141	37.6	8,719	53.4
Wisconsin	338,437	22,219	6.6	6,920	31.1	12,559	56.5
Wyoming	33,287	5,127	15.4	2,046	39.9	2,487	48.5

Note: Both numbers and percentages are weighted. Data Source: 2009 American Community Survey.

District of Columbia for proportion of uninsured pre-retirement age women who would be eligible for Medicaid), Vermont (50th), Hawaii (48th), New York (40th), and Arizona (27th).

Furthermore, many states will benefit from the premium credits and cost-sharing subsidies to be used in the Exchanges. States with the highest number of eligible, currently uninsured pre-retirement age women were South Dakota (69.2%), Vermont (67.5%), and Delaware (64.7%).

Overall, the results show that if health reform legislation had been enacted at the time of survey (2009) and all uninsured women who were eligible for the new health insurance programs had participated in the new programs, only 1.9% of pre-retirement age women would continue to be uninsured, compared with the existing 2009 noninsurance rate of 11.7%. In addition, Mexican-American and other Hispanic pre-retirement age women are set to benefit most from the premium credits and cost-sharing subsidies as part of the new Health Insurance Exchanges, with a substantial but smaller proportion benefiting from the expansion in Medicaid.

Although these analyses have focused on the impact of health care reform for pre-retirement age women who had no health insurance in 2009, there is a large segment of this population who are underinsured through inadequate private insurance coverage. Also, some of those who are already purchasing

adequate private insurance find the cost an enormous financial burden. Additional ancillary analyses (available upon request) indicate that more than 52% of all pre-retirement age women who purchase some or all of their health insurance on their own (7.5% of all pre-retirement age women) would be eligible for Medicaid or premium credits in the Exchanges.

Discussion

Pre-retirement age women are a particularly vulnerable group and are at high risk of lacking adequate health insurance coverage to care for their higher rates of disability as they age (Xu et al., 2006). Unfortunately, many women at this age do not have health insurance coverage and are at high risk of losing health insurance as their older husbands, whom they depend on for employer-sponsored private health insurance, age into the Medicare system (Angel et al., 2010). In addition, pre-retirement age minority women, particularly Hispanic women, have much higher rates of noninsurance than their non-Hispanic White counterparts. The expanded Medicaid program and access to premium credits and cost-sharing subsidies program will greatly benefit the underinsured and uninsured. By using data on health insurance coverage from 2009, applying the health reform changes set to take place in 2014 and assuming that all pre-retirement age women who are eligible will enroll in Medicaid or purchase insurance through the Exchanges, our study shows that rates of noninsurance for this group will decrease from 11.7% to just 1.9%.

Medicaid Expansion and the States

Minority women, and particularly Mexican-American and other Hispanic women, have much lower rates of Medicaid participation than other groups. Part of this can be attributed to Hispanic women's lower participation rates in public programs in general; however, many Hispanic pre-retirement age women also live in states where the current Medicaid income eligibility thresholds are lower (sometimes substantially) than the proposed expansion to 133% of the FPL in the PPAC Act. For example, Mexican Americans account for 16.2% of the pre-retirement age women in Texas, the largest proportion of all states. However, Texas also has one of the strictest Medicaid income eligibility criteria at 26% of the FPL for parents (Kaiser Family Foundation, 2009a). Texas is only marginally beaten for the lowest Medicaid income eligibility threshold by Arkansas (17%), Alabama (24%), and Indiana, Louisiana, and Missouri (all at 25%) (Kaiser Family Foundation, 2009a). Most significantly, Texas does not extend Medicaid eligibility to childless adults, which particularly affects pre-retirement age women, who are less likely to have children living in their household than their younger counterparts. By setting a federal minimum standard for Medicaid eligibility and expanding Medicaid eligibility to all persons living at or below 133% of the FPL (not just children, parents, pregnant women, persons with disabilities, and some elderly), the PPAC Act extends Medicaid to many pre-retirement age women. A large portion of pre-retirement age minority women live in states that have especially restrictive existing eligibility criteria, meaning new federal requirements will help to close the gap in insurance rates between minority women and their non-Hispanic White counterparts. Perhaps most important, state Medicaid coverage must meet adequate standards of care as defined by the federal government, and it must match the same standard offered as the minimum benchmark package through the Exchanges (Kaiser Family Foundation, 2010). Despite these new standards outlined in the new health care law, there remains potential for states to implement these standards differently, even more so with many state budgets currently in fiscal crisis and looking for ways to decrease Medicaid rolls (Stolberg & Sack, 2011). In addition, because of the high concentration of Hispanics in several states, which states ultimately implement the new eligibility thresholds as written could moderate or exacerbate the racial and ethnic disparities in access to health insurance estimates that are presented in these analyses.

Insurance Stability Through the Exchanges

For pre-retirement age women, the decoupling of private health insurance from the labor market through the Exchanges and premium credits and cost-sharing subsidies will greatly improve access to adequate and affordable health insurance. Recent research suggests that pre-retirement age women are less likely to receive employer-sponsored health insurance and more likely to lose private coverage through the retirement of their partner, marital separation, or widowhood (Lavelle & Smock, 2010). This is a vulnerable time when pre-retirement age women also experience greater rates of disability than their younger counterparts, sometimes making private insurance unaffordable (Lambrew, 2008). This is particularly true for minority women who, on average, have lower incomes than their non-Hispanic White counterparts and are more likely to work in industries that typically do not provide employer-sponsored health insurance (Harrington Meyer & Pavalko, 1996). In 2009, for example, 70.6% of pre-retirement age non-Hispanic White women had some health insurance provided by an employer, compared with only 58% of African-American women and 47.4% of Hispanic women. The Exchanges will allow pre-retirement age women to purchase health insurance at a cost made more affordable through the credits and subsidies. Furthermore, by detangling private insurance from the workforce, women who purchase health insurance through the Exchanges will experience greater health insurance stability by not having lapses in coverage through job loss or transitioning between jobs.

Although the health care law, as written, should increase access for pre-retirement age women through these exchanges, current court challenges to the constitutionality of the Individual Mandate may have serious implications for the availability and affordability of insurance through these exchanges should these court challenge be successful (Buettgens, Garrett, & Holahan, 2010).

Access and Uptake

The results in this study are assuming that every uninsured pre-retirement age woman eligible for Medicaid and/or the Exchanges will now participate. However, in reality this is unlikely to be the case. Hispanics, in particular, are often cited for their lower-than-average participation rates in public assistance programs. One of the most often cited reasons is that many Hispanics are non–English-speaking immigrants, and hence are more likely to experience language barriers. Language barriers can mean that people eligible for public programs may have difficulty understanding the applications and application process, and outreach and program materials may not be targeted towards them (Fomby & Cherlin, 2004). In addition, prior research has suggested that although Medicaid is generally

viewed in a positive light by people eligible for the program, the negative stigma associated with welfare recipients has been linked with a reduction in Medicaid enrollment (Stuber & Kronebusch, 2004). This stigma may prevent the enrollment of newly eligible persons, particularly those who have a higher income, on average, than those persons eligible with lower incomes.

Despite these reasons for the discrepancy between those eligible for public programs and the actual participation rate, the Individual Mandate that comes into effect in 2014 and the streamlining of information about health insurance plans in the Exchanges may promote greater participation rates. The Individual Mandate requires citizens and legal residents to have a certain level of health insurance coverage. Those who do not have the required amount of coverage are charged an annual penalty, with the amount determined by household size and income. The penalty amount may be a big enough incentive, particularly for those eligible to participate in Medicaid, to enroll in Medicaid or buy private insurance through the Exchanges.

In addition, the PPAC Act creates regulations for the dissemination of information and means of access related to purchasing insurance through the Exchanges. For example, all health insurers participating in the Exchanges must meet certain benchmark requirements and contract with other organizations to conduct outreach and enrollment assistance. Insurers must also use a uniform enrollment form and present plan information in a standard format for ease of comparison among all plans (Kaiser Family Foundation, 2010). Additionally, the state-run Exchanges must establish a customer service call center and construct procedures for determining whether an enrollee is eligible for premium credits, as well as a standard, single form for applying for cost-sharing subsidies. The PPAC Act requires that the premium credits and cost-sharing subsidies enrollment form be available to fill out on-line, by mail, by phone, or in person. Finally, for non–English-speaking participants in the Exchanges, the new law mandates that information must be presented in a culturally and linguistically appropriate manner (Andrulis, Siddiqui, Purtle, & Duchon, 2010).

Although clauses in the new law call for greater uniformity in presenting plan information and choices in plans, choosing a plan that meets the unique health need s of each person may be cumbersome. For example, evidence from the recently implemented Massachusetts health insurance exchanges shows that even with uniform information, plans may be complicated to choose from in terms of predicting what one's health care needs may be in the present and the future (Sered & Proulx, 2011).

Finally, in addition to the Medicaid expansion and the Exchanges, the PPAC Act benefits women, and in particular older women, through regulations that minimize private insurers' ability to charge higher rates for women and the elderly. The new law now prohibits insurers from assessing risk premiums based on gender, and requires that premiums for older adults be no more than three times that of younger adults. These requirements must be enforced by 2014 (Kaiser Family Foundation, 2010).

Health Care Reform: Will Disparities Persist?

The results clearly show that pre-retirement age minority women will considerably benefit from Medicaid expansion and the Exchanges. However, Mexican-American and other Hispanic women are still overrepresented among those who will remain uninsured. The data in Table 3 displays pre-retirement age women by race and ethnicity in the total sample and of those, who would remain uninsured if health reform changes were implemented today. Mexican-American pre-retirement age women, although only comprising 3.3% of the total sample, represent 5.7% of the pre-retirement age women who would remain uninsured.

Table 3
Women Aged 55 to 64 Years Old with No Health Insurance After Health Reform

	Total Sample		Total with No Insurance	
	n	%	*n*	%
Non-Hispanic White	13,445,866	74.6	195,438	57.4
African American	1,951,759	10.8	36,642	10.8
Mexican American	596,570	3.3	19,500	5.7
Other Hispanic	446,983	2.5	20,757	6.1
Other race	1,595,645	8.9	68,194	20.0
Total	18,036,823	100.0	340,531	100

Note: Both numbers and percentages are weighted. Data Source: 2009 American Community Survey.

Part of this gap in coverage can be attributed to the requirement that legal immigrants must have lived in the United States for at least 5 years before being eligible to participate in Medicaid. More than 17% of Mexican-American and close to one quarter of other Hispanic pre-retirement age women who would remain uninsured after health care reform would have qualified for Medicaid had the 5-year legal requirement not been included in the legislation. In addition, undocumented immigrants are prohibited from participating in Medicaid and using their own funds to purchase insurance through the Exchanges.

Conclusion

This paper presents new estimates of the number of women aged between 55 and 64 who are eligible to benefit from the expansion in affordable health insurance coverage mandated through the PPAC Act. However, the results presented here are based on data from 2009, whereas many of the changes that will provide greater access to health insurance are not mandated to be implemented until January 1, 2014. The continual diversifying of the United States population means the women that were part of our sample here will look different from the women who will be part of the pre-retirement age cohort come 2014, with a greater proportion of the U.S. population consisting of racial and ethnic minorities. If trends of lower health insurance coverage persist for pre-retirement age minority women, the health reforms that expand coverage to the underinsured and uninsured will have a greater impact than the results in this paper estimate.

Future research needs to extend these current best-case estimates and simulate levels of coverage based on potential state-level discrepancies in implementation of the new health care law. For example, it will be especially useful to simulate Medicaid coverage levels for states that may be successful in attempts to postpone implementing new Medicaid eligibility thresholds and to estimate the participation and cost of insurance through the Insurance Exchanges in the absence of an Individual Mandate.

In addition, research needs to explore further the affordability of private insurance purchased through the Exchanges, even with the assistance of premium credits. This will be particularly important for the near-poor, who do not qualify for Medicaid and have limited flexibility in their financial resources to purchase

health insurance. In addition, attention needs to be paid to issues surrounding Mexican American and other Hispanics' participation in public programs. This information can inform the implementation of new recruitment and enrollment procedures during the Medicaid expansion. Finally, researchers should prepare to measure the impact of health reform during and after its implementation, particularly for those who have been most vulnerable to health insurance instability: Women, minorities, and the aging.

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Author Descriptions

Kate C. Prickett is a doctoral student in the Department of Sociology and The Population Research Center at The University of Texas at Austin. Her research examines socioeconomic disparities in health care, long-term care, and social policy implementation.

Jacqueline L. Angel is a Professor of Public Affairs and Sociology at the University of Texas at Austin. Her research interests focus on social policy issues related to diversity, health, and aging with a special emphasis on Hispanic Families.