Health Care Reform: What Women Need

ISSUE BRIEF

Introduction

Health care is central to the well-being of women and families. It is a key determinant of their quality of life, their economic security, and their ability to thrive and prosper. Women are often the primary health care decision-makers for their families - choosing the providers who care for their spouses, children and aging parents; making and sharing in treatment decisions; and coordinating and providing much of the care themselves.

Unfortunately, in many – and perhaps most – ways, our health care system is failing women. They experience high costs, inadequate coverage, and poor quality care. Many young women lack access to affordable, high quality primary and preventive care, as well as the maternity, newborn and pediatric services they need. Women in their middle years who still care for their children also cope with the system's failures as they become caregivers for older relatives who are living longer with more complex chronic conditions than ever before. And then they begin to develop their own chronic conditions. They find a health care system incapable of providing adequate coordination or quality care, and as a result, women and their families bear the enormous physical, emotional and financial costs of our health care crisis.

Women are ready for a change. A recent survey found that 76 percent of women support or strongly support health care reforms.[1] Yet any change will not do; women need change that will solve problems and address our needs. To get that, we must understand how proposed changes will work and what policy options will work best for us and our families.

Affordability

The high cost of health care is a huge problem for women, who are more likely to need and use services but often have less ability to pay. This is because, on average women have lower incomes than men, and a greater share of their income is consumed by out-of-pocket health care costs.[2] Over the past nine years, health insurance premiums have more than doubled, increasing four times faster than wages.[3] In the past year alone, health care costs for a typical American family of four have increased by 7.4 percent – from $15,609 to $16,771.[4] These high costs price many women out of the insurance market completely. Because women are twice as likely as men to be covered as dependents,[5] the high cost of family coverage relative to single coverage threatens their and their children's access to insurance.

Continuing escalation of health care costs is not sustainable. Women and families are already overburdened. The high cost of health care not only cuts into their disposable income and increases their debt, but in many cases it makes it all but impossible for women to afford basic necessities such as food and rent.

From 2001 to 2007, the percentage of women making less than $20,000 per year who spent at least a tenth of their income on health care rose dramatically from 29 percent to 55 percent.

Women earning more did not fare much better over this time period – 41 percent of women making between $35,000 and $60,000 per year reported having high out-of-pocket costs in 2007, up from 21 percent in 2001.[6] Paying for care is most difficult for adult women under age 50, likely because they are

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responsible for medical costs for both themselves and their children.[7]

Even though plans with lower premiums seem affordable, their high cost sharing puts women and families at risk because the costs can skyrocket if someone falls ill. As a recent Georgetown University Health Policy Institute report points out, "over 18 months of active treatment, a breast cancer patient might have as many as 140 doctor and other treatment visits and require up to 40 prescription refills. If a co-pay of $25 applied for each, her expenses due to co-pays alone would be $4,500."[8]

Women are more likely to own or work for the smallest businesses, which struggle to provide health insurance coverage to employees.

Recommendations

To address cost and affordability, the federal government must provide meaningful financial assistance in the form of substantial tax credits or direct subsidies to low- and middle-income families to help them purchase coverage. The government should also establish out-of-pocket payment caps based on individual or family income. This cap should cover premiums and all cost sharing, including co-payments and deductibles. And each family's annual out-of-pocket costs should be capped on a sliding scale, with no family being asked to pay more than 10 percent of their income for coverage.

In order to help those most in need, Medicaid eligibility should be expanded to a national "floor" of at least 150 percent of the Federal Poverty Level (FPL). Medicaid is a particularly vital source of care for women of reproductive age. In 2006, 7.3 million women of reproductive age relied on Medicaid for their health coverage, including 37 percent of those with family incomes below the federal poverty level.[9] Households headed by single women struggle financially more than households headed by single men; almost twice as many households headed by a single female (46 percent compared to 25 percent) are below 150 percent of the FPL.[10] Low-income individuals are best served in the Medicaid program because of its comprehensive benefits and strong cost sharing protections. Medicaid eligibility must also be extended to low-income adults without children. These individuals include some of our most vulnerable citizens, often with severe cognitive limitations and significant chronic health challenges. Further, individual mandates should not be put into effect until after all federal rating rules, financial assistance and employer mandates are fully implemented. Penalty structures to enforce adherence to mandates must be progressive, so that lower income people are assessed a lower proportionate penalty. If penalties are pegged to premium amounts, it would not be fair to charge people higher penalties for failure to purchase coverage simply because of their age or other characteristics (i.e., tobacco use). Individuals who are exempt from the penalty because of hardship or other factors should receive proactive assistance in order to access affordable, meaningful coverage.

The federal government, in partnership with the states, will need a long-term, nationwide consumer education campaign prior to mandating that everyone purchase coverage. This public education must include what each individual should do in order to comply with the mandate and the range of resources available to help people access affordable coverage.

Choice of Plan

Many women are severely limited in their choice of insurance coverage. Women are more likely to own[11] or work for the smallest businesses,[12] which struggle to provide health insurance coverage to employees. Women also are more likely to work for firms that pay low wages, about three-quarters of which are smaller firms[13] which often deny employees a choice in insurance plans, if they offer coverage at all. This situation is made worse by the fact that insurance markets across the country have consolidated to a dangerous level, especially in rural and low-population states.

A recent report by Health Care for America Now showed more than 400 corporate mergers involving health insurers in the past 13 years, leaving one or two large insurers dominating many statewide markets.[14] In Alabama for example, one insurer controls 89 percent of the market. Such monopoly power allows insurers to increase premiums to outrageous levels, forcing people to choose between unaffordable premiums and going without insurance. This puts them at risk for poorer health outcomes.

And while it is important to have an opportunity to choose a plan, too many choices can be overwhelming and can actually have negative consequences,[15] especially if there is a lack of clear information on how to compare plans.

For millions of American families, women will be gathering the information, comparing plans, and making the decision about which plan is best. Yet many women still do not have easy access to a computer with an internet connection. These women need a trusted independent resource where they can get unbiased information about plan choices so they can assess plans based on cost, quality, provider network, and comprehensiveness of benefits. It also is essential that women are informed about what their family's likely financial exposure will be with any given plan.

Recommendations

A health insurance exchange can help consumers make informed choices by fostering a transparent marketplace where insurers compete for enrollees based on the cost and quality of their benefit packages. Any insurer participating in the exchange should be required to offer a minimum benefit package that covers a basic, comprehensive set of services with limits on out-of-pocket costs. Beyond this basic package, the exchange should establish tiers of plans with restrictions on benefit design to maximize choice while ensuring that insurers cannot target their benefits packages to healthy, less costly consumers by offering discounts on gym memberships but not covering certain chemotherapy drugs, for example.[16]

While many insurers claim women's additional reproductive health costs justify their gender-rating, few actually provide maternity coverage.

To ensure that consumers are not overwhelmed, the exchange should limit the number of plan options. Each tier of coverage in the exchange also needs a clearly-defined benchmark. While there has to be some flexibility in plan design to encourage innovation and give people choices that meet their needs, there must be standards that make it easy for consumers to compare plan benefits both within and across tiers. States can help provide consumers by providing information and trouble-shooting services so they can make the best decisions for themselves and their families. The exchange should have up to a one-year enrollment period in order to give women and families sufficient time to understand their options and make informed choices.

Trusted nonprofit consumer organizations can educate and advocate for individuals and communities with help-lines and walk-in aid centers.

Market Protections

Insurers today can turn people away, raise rates or drop coverage based on a person's health history, and they can delay or deny essential care. In many states, discrimination in premiums is permitted based on gender, age and health status. For example, some insurers have denied women coverage because they had a c-section or even for minor conditions, like acne.[17] In many states, they can and do charge women higher premiums simply because of their gender.

While many insurers claim women's additional reproductive health costs justify their gender-rating, few actually provide maternity coverage.[18] Similarly, the practice of age rating is closely associated with health status. As Americans age they are more likely to experience chronic conditions such as heart disease, cancer, stroke and diabetes. Women make up the majority of the uninsured among the pre-Medicare population (age 55-64), in part because they lose their dependent coverage if their spouse goes on Medicare.[19] Too often, premiums are priced out of reach for these women at the time when they need health care the most.

Recommendations

To protect women from unfair market practices, federal rating rules should be applied to all individual and fully insured group markets, inside or outside any new exchange, requiring guaranteed issue and guaranteed renewability. Insurance companies must be prohibited from excluding coverage because of pre-existing conditions and raising rates based on gender or health status. Age and lifestyle rating must be limited. We should not, with one hand, prevent insurance rating based on health status and then, with the other hand, allow age or lifestyle rating that will have the same effect.

There should be bans on lifetime and annual caps on coverage, which can put a devastating financial burden

on people with chronic conditions. States that have community rating or tighter rate bands than federal requirements should not be required or incentivized to weaken their rules.

Adequate Coverage

Many insurance plans do not provide comprehensive coverage, particularly to women. For example, a recent study showed that 62 percent of bankruptcies filed in 2007 were linked to medical expenses. Of those who filed for bankruptcy in 2007, nearly 80 percent had health insurance.[20]

Although women's health care needs are not limited to reproductive health, it is a key determinant of their overall health. Women's reproductive health needs require them to get regular check-ups whether they have children or not. Women need regular screenings for reproductive health cancers, during and after their reproductive years.

Women are more likely than men to need prescription medication[21] and to require treatment for a chronic condition.[22] While some states mandate coverage of specific benefits, federal law is extremely vague on what constitutes adequate coverage. Too often essential services and treatments used only by women – such as maternity care - are not covered.[23]

The form and comprehensiveness of benefit packages are critically important, and it is essential that items and services important to women are covered, such as maternity care, well-woman and well-child visits, cancer screening, and reproductive health services and supplies.

Nearly half of women reported postponing or not receiving a cancer screening or dental exam because of financial concerns.

Recommendations

To be meaningful, health reform legislation must set a nationwide standard for health benefits that covers what people need to get and stay healthy and to be treated when they are ill. All health insurers in the non-group and group markets, whether participating in the exchange or not, should be required to offer a minimum essential benefit package that sets a floor for all pubic and private insurance plan options, including at least preventive and primary care, emergency services, hospitalization, physician services, maternity and newborn care, medical and surgical care, prescription drugs, mental and substance abuse services.

Any benefits package should guarantee that women receive all the health care services they need – including reproductive and maternity care – at all ages/stages of life. Access to reproductive health services must be comparable to access to any other primary or preventive health care services, without targeted exclusions. In fact, the majority of private health plans recognize that reproductive care is essential to women's overall health and include a full range of family planning services in their benefit packages. Any targeted exclusions of reproductive health could result in many women losing coverage of benefits they currently have. To help ensure that low-income women have access to comprehensive coverage, eligibility for family planning services and supplies under Medicaid should be expanded.

A panel of medical experts, consumer advocates, and other key stakeholders, making decisions in an open and transparent way, should determine what specific items and services will be covered, and with what cost sharing. States or exchanges should then have the ability to establish mandates or adequacy standards above and beyond the minimum package. There must also be a ban on lifetime or annual limits on any benefits

Preventive care is particularly important to improve health and decrease long term costs, but there is strong evidence that even nominal cost sharing for evidence-based preventive and screening services can be impede people's ability to access those services. This is particularly true for women, nearly half of whom reported postponing or not receiving a cancer screening or dental exam because of financial concerns (compared to 36 percent of men) in a recent survey.[24] Moving forward, insurance plans should be required to waive any cost sharing for critical preventive and screening services, including pregnancy prevention.

Reliability

Once a woman has chosen a plan that is affordable and provides adequate coverage for her or her family, there is little assurance that it will be there over the long haul. There is significant instability in the

insurance market, with an average of two million Americans losing or changing their health insurance every month.[25] Often this is outside of an individual's hands; insurance plans change their offerings or provider networks, an individual loses her job or has to cut back to part-time work to care for a child or aging parent, or public programs cut or change eligibility requirements. Low-income Americans are most likely to be affected; more than two-thirds went without health coverage at some point from 1996 to 2000.[26] The recession will make matters worse, as workers lose jobs and employers cut back on benefits.

Recommendations

To help increase the reliability and stability of health coverage, especially for women and low-income individuals, the government must eliminate barriers to enrollment in public programs. States should not require time-consuming face-to-face interviews to determine eligibility. They should implement continuous eligibility and seamless and convenient enrollment and redetermination processes – critical components to ensuring that those who are eligible for public programs get – and stay – enrolled. And any new health insurance exchange should provide mechanisms to automatically match women and families to any programs for which they might be eligible, such as Medicaid, the Children's Health Insurance Program, or subsidized private coverage.

Another way to ensure stability and continuity in the marketplace is through a public health insurance plan option. A public health insurance option can help provide a "benchmark," to give consumers something against which to compare private plan options. It can also serve as a source of stability and continuity in the marketplace, particularly for rural and underserved areas, or areas in which there has been significant plan consolidation. In addition, it can help keep premiums low over the long term by implementing payment and delivery system reform to promote prevention and chronic care management, reduce administrative costs, and standardize claims, payment and other processes.

Quality and Cost

Health care is increasingly recognized as a shared responsibility among individuals, employers, providers, insurers and the government. Yet families are not getting good value in the form of high quality care and contained costs for their investment in this "shared responsibility" structure. America's health care system is largely blind to quality, outcomes or appropriateness of the care delivered and received.

Despite spending more than any other country on health care[27] and being home to some of the brightest, best trained, and most committed health care professionals in the world, patients are not getting the best care in the world. From 2004 to 2006, patient safety incidents resulted in 238,337 potentially preventable deaths and cost Medicare $8.8 billion.[28]

Women and people of color tend to receive lower quality health care, even when insurance status, income, age and severity of conditions are considered.

On average Americans only get the right care for their condition 55 percent of the time.[29] Women and people of color tend to receive lower quality health care, even when insurance status, income, age and severity of conditions are considered. [30] Quality also varies widely depending on where a patient lives.[31]

Recommendations

Delivery system reform must put patients first. This is especially important to the most vulnerable patients -- those with multiple serious chronic conditions, and whose medical conditions are complicated by physical or cognitive impairment or whose access to health care is already limited by their low income, race or ethnicity. We have good models of patient-centered care from research and clinical practice, which demonstrate that it is possible to deliver better care and reduce health care costs. Whatever model we choose, it must account for patients' wants and needs. By that, we mean that:

- Care is comprehensive, coordinated, individualized and planned;
- Patients' experience of care is routinely assessed and improved;
- Patients and their caregivers are full partners in their care;
- Transitions between settings of care are smooth, safe, effective and efficient;

- Patients can get care when and where they need it;
- Care is integrated with the community resources patients need to maintain health and wellbeing; and
- Continuous quality improvement and the elimination of disparities are a top priority.

As we prepare to overhaul the nation's health care system, we must take two key steps to ensure we satisfy these requirements of patient-centered care. First, we must change the way our nation pays for health care by moving from a system that pays for volume of services, no matter what their value, to a system that rewards quality and patient-centered care. This will require a fundamental shift in payment to foster, and perhaps force, redesign of physician practice; and ensure that our most vulnerable, high-risk and high-cost patients get the care coordination they need.

Second, it is critical that we strengthen our health care infrastructure. This means:

- Building a strong foundation of measurement, public reporting and ongoing quality assessment and improvement;
- Encouraging widespread adoption of health information technology that helps us improve quality, coordination and safety;
- Robust federal support for comparative effectiveness research to give clinicians and patients better information about what works and what doesn't;
- Integrating the right tools and strategies to engage patients and caregivers in managing their health and making health care decisions; and
- Investing in an adequate health workforce, appropriately trained, in sufficient numbers and effectively deployed to meet the needs of our population, particularly those who have been traditionally underserved and the rapidly growing number of individuals with multiple chronic conditions and geriatric syndromes.

Any reform proposals also need to strengthen the existing network of community-based safety-net health care centers, including women's health centers and HIV/AIDS clinics, which serve as critical sources of primary and preventive care for low-income women who need family planning and sexually-transmitted infection services.

Conclusion

For women and their families, there is no more urgent priority than health care reform. They need a health care system that provides affordable choices, comprehensive coverage, and access to health professionals and institutions that deliver the highest quality care.

This is a long-awaited moment of extraordinary opportunity for the nation, when a genuine transformation of our health care system is finally possible. The magnitude and urgency of the crisis we face demands that we act boldly. To do anything else is morally and fiscally irresponsible.

The National Partnership for Women & Families is a non-profit, non-partisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at www.nationalpartnership.org.

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