FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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HEALTH REFORM: Implications for Women's Access to Coverage and Care

Introduction

Health care continues to be a fundamental policy priority for women, reflecting their experiences with the health care system as patients, mothers, and caregivers for frail and disabled family members. Women's priorities for health care reform cut across a range of topics, including access to health insurance coverage, health care affordability, scope of benefits, reproductive health, and long-term care. This brief highlights the key issues for women that arise in the context of health reform, and are still under debate. It focuses on the current leading proposals from the House of Representatives, which passed the Affordable Health Care for America Act (HR 3962) on November 7, 2009, and the Senate, which is currently debating a bill, the Patient Protection and Affordable Care Act (HR 3590). Should the Senate pass a bill, differences between the bills from the two chambers will need to be negotiated and reconciled in a conference committee before a single, final bill can be presented for vote, approval by the President, and ultimately enacted into law.

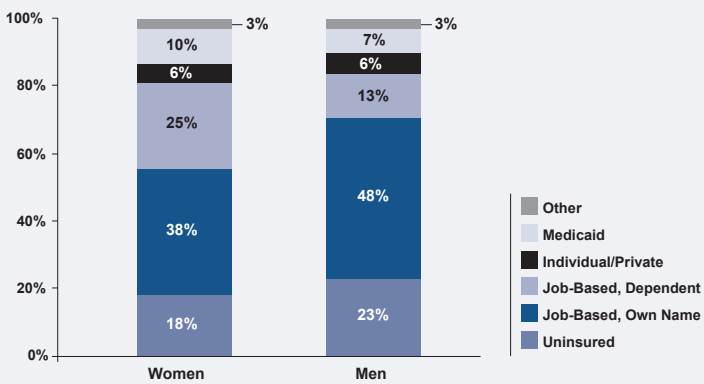
Improving Access to Insurance

The thrust of the health reform debate currently underway is on expanding coverage to the uninsured by creating a system where nearly all individuals can obtain some form of insurance and cutting health care costs. Individuals who currently have insurance can keep the coverage they have. The current proposals from the House of Representatives and Senate[1] require that all individuals have some form of health insurance and that employers must provide coverage to workers and their dependents or pay an annual fee. These proposals would establish national or state-level health insurance "exchanges" or "gateways," in other words a mini-marketplace of health plans, where small businesses and uninsured individuals can obtain coverage regardless of their health or work status from a choice of private or public plans. The proposal from the House of Representatives includes a public plan in the national Exchange and the Senate bill originally included an optional public plan in the state-based exchanges, but alternatives are now being considered in the Senate debate. Both of the proposals would require that the plans participating in an exchange would need to provide a minimum level of benefits. A graduated system of subsidies would be developed to help lower-income individuals purchase coverage and for very low-income individuals, Medicaid would be expanded.

Employer-Sponsored Coverage: Most women and men in the U.S. are covered by insurance obtained through the work place (Figure 1).[2] Women with employer-based insurance are almost twice as likely as men to be covered as dependents which can make them more vulnerable to losing their insurance should they become widowed or divorced or if their husbands lose their jobs. Only half of working women are able to get health coverage through their jobs compared to 57% of men. On average, workers pay 27% of the premiums for family coverage, an average of $3,515 annually.[3] On top of that, many workers must pay annual deductibles and co-payments for physician visits, which in a PPO plan average $1,488 for the family deductible and

Figure 1

Health Insurance Coverage of Adults, Ages 18–64, by Gender, 2008



Note: Other includes Medicare, TRICARE, and other sources of coverage.
Source: Kaiser Family Foundation analysis of the March 2009 Current Population Survey, US Census Bureau.

$21 co-payment for every in-network primary care physician visit. Affordability of care is a key issue for women, even among privately insured women with 14% reporting that they delayed or went without needed health care because they could not afford associated costs.[4] The effects of costs as a barrier are magnified for women with lower incomes.

The House and Senate proposals would also offer greater stability of coverage for workers employed by small businesses as they all make reforms in the small group market that would require guaranteed issue and renewability.

Individual Market: Nationally, about six percent of women purchase coverage through the individual insurance market.[5] Currently, these plans can deny coverage to individuals with a "preexisting condition" such as pregnancy, mental illness, or chronic condition. They can also refuse to renew coverage for individuals with health problems or raise the premium rates to levels that are unaffordable to policy holders. Furthermore, in 38 states, insurers can charge women who purchase individual insurance more for the same coverage than men, a practice called gender rating.[6] A national study found that, in these states, a 40 year old woman could be charged anywhere from 2% to 140% more than a 40 year old man with the same health status for the same individual policy. [7] In 2008, an estimated 4.7 million women purchased individual insurance in states that permitted gender rating.[8] The House and Senate plans ban the practices of gender rating, pre-existing condition exclusions, and varying premiums based on health status. Despite the practice of gender rating, many individual insurance plans either do not cover maternity care or require women to purchase separate riders for maternity coverage, often with waiting periods. In plans where riders are available, the monthly cost of riders offered to a 30 year old woman range from $38.00 to $1270.33, sometimes exceeding the costs of a basic policy.[9] The House and Senate plans specifically identify maternity care as an essential benefit that must be covered by all plans offered through an exchange or gateway.

Medicaid: One in ten women is covered under Medicaid, the state-federal program for low-income people and women comprise over two-thirds of adult Medicaid beneficiaries.[10] Women are more likely than men to qualify for Medicaid because, on average, women have lower incomes and they are also more likely to fall into one of the program's eligibility categories: pregnancy, parent of dependent child, over 65, or disabled. Because of these restrictive "categorical" requirements, adults without children typically do not qualify for Medicaid, no matter how poor they are. Medicaid covers a broad range of services that are important to women, financing 4 in 10 births in the U.S, nearly two-thirds of all publicly funded family planning services, a wide range of preventive screening services without copayments, and long-term care services.[11] The leading proposals from the House and Senate would eliminate the "categorical" requirements for Medicaid and base eligibility solely on income. The House plan would extend coverage to all individuals with incomes up to 150% FPL, and the Senate proposal would go up to 133% of FPL.

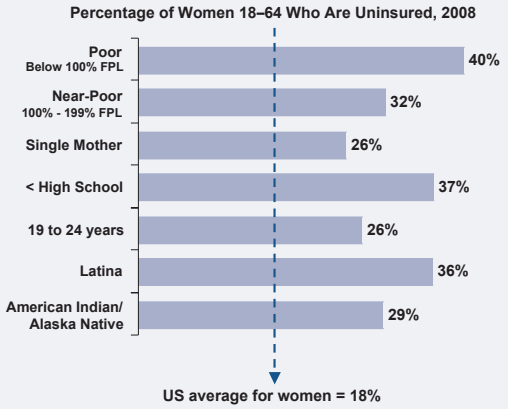
Medicare: More than half (56%) of all Medicare beneficiaries are women; among those ages 85 and older, 70% are women.[12] Women on Medicare have significant health needs and on average live longer and experience higher rates of many chronic health conditions than men. However, the program has relatively high cost-sharing requirements, which can be prohibitive for many seniors, particularly women, who have fewer financial resources than men. In addition to affordability challenges, the Medicare program has some notable gaps in coverage. It has very limited coverage for long-term care and does not cover essential services such as vision and dental care. Furthermore, some preventive benefits important to women's health, such as mammography, clinical breast exams, bone density tests, and visits for Pap test and pelvic exams, require 20% coinsurance. The House and Senate bills propose to eliminate all cost-sharing as well as raise payments for certain proven preventive services under Medicare, such as mammograms, pap smears, and bone density screenings.

The major reform proposals emphasize finding cost savings within the Medicare program, such as greater attention to geographic variation in spending across the country and major changes in Medicare Advantage payments. There are also several incentives included in various plans for providers to improve quality and lower cost simultaneously. For example, both plans include provisions to lower payments to hospitals with higher rates of readmissions among Medicare patients.

Uninsured: Despite this patchwork of coverage, more than 17 million women—18% of nonelderly women—are uninsured. While health insurance is an important workplace benefit, the availability of coverage is limited for those who are unemployed, work part-time, lose jobs in economic downturns, and lower wage workers. Access to this system can be tenuous for some women, who are less likely than men to work full-time, as they are more likely to take time away from paid work to raise children and care for other family members. Even with the prominence of employer-based coverage, two-thirds of uninsured women are in households with a full-time worker. Poor and low-income women, single mothers, young women and Latina and Native American women are uninsured at higher rates than other groups (Figure 2).

Figure 2

Women at High Risk for Being Uninsured



Note: The federal poverty level (FPL) was $17,600 in 2008 for a family of three.
Source: Kaiser Family Foundation analysis of the March 2009 Current Population Survey, US Census Bureau.

The proposals in the House and Senate require individuals to have coverage and include provisions to help make coverage more affordable by both capping out-of-pocket spending and providing subsidies to individuals seeking to purchase coverage within an exchange. The subsidies (called "premium credits") vary by income level and can be applied to premiums and other cost-sharing expenses. The House and Senate bills propose varying levels of subsidies for families with incomes up to 400% of poverty, approximately $73,000 annually for a family of three. The details of final legislation will make a big difference in whether coverage is actually affordable to women and whether subsidies and limits on out-of-pocket spending provide sufficient protection from health care costs.

Benefits of Importance to Women

The bills in the House and Senate do not detail the benefits that will be offered by plans participating in an exchange beyond listing broad categories of services. Both bills would establish an "essential benefits package," comprised of the services that all plans must cover at a minimum and also allow for plans to cover benefits beyond this minimum threshold. Some of the categories that are mandated for coverage in an essential benefits package include hospitalization, physician services, outpatient services, prescription drugs, rehabilitation, and mental health care. Some benefits of importance to women, however, are addressed to varying degrees in the reform proposals, including preventive services, reproductive care, and long-term care. Under the House proposal, the essential benefit package will be designed by an advisory council that is chaired by the Surgeon General and comprised of medical, public health, and policy experts. Under the Senate plan, the Secretary of the Department of Health and Human Services would have responsibility for benefit design.

Prevention: Both of the health reform proposals from the House and Senate emphasize the value of prevention, particularly with an eye toward saving future costs on avoidable procedures and services. Many of the conditions that are growing among women, including heart disease, diabetes, as well as cancers most likely to afflict women—breast, lung, colorectal, and cervical cancers—all respond much more effectively to treatment when identified early through screening tools, and some may be prevented, for example with the HPV vaccine.

Both bills require that at a minimum, plans participating in an exchange include coverage of preventive services that have been given an "A" or "B" grade and recommended by the current US. Preventive Services Task Force (e.g. Pap smears, routine mammography after age 50, and STI screening) and exempt these services cost sharing. On December 3, 2009, the Senate approved amendments to the leadership bill that could expand the range of preventive services for women that private insurance plans can cover without cost sharing to include additional services that would be recommended in the future by the federal Health Resources and Services Administration (HRSA), as well as including mammography coverage for women in their forties.[13] In addition, health reform

proposals stress the value of evidence-based services, including for prevention, and both of the leading proposals include provisions for limiting Medicaid and Medicare reimbursements to preventive services that have met a certain level of proven effectiveness.[14]

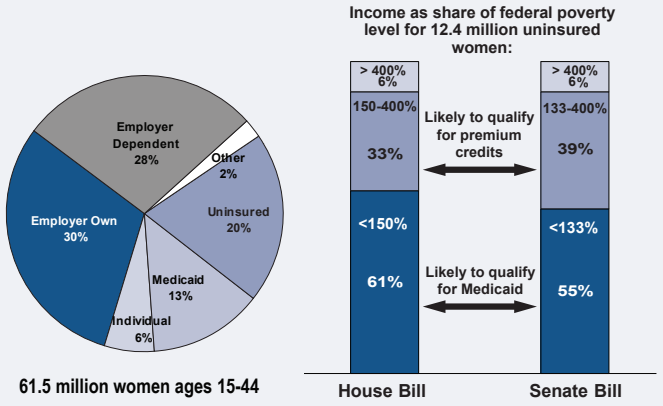
Reproductive health care: Reproductive health needs span across a woman's life and take many forms, including contraception, prevention, screening, and treatment of sexually transmitted infections, maternity care, infertility services, abortion, and menopause management. Contraception is one of the most widely used services among women. Most workers in employer-sponsored plans are now covered for contraceptives. [15] However, unlike maternity care, family planning counseling and contraceptive devices are not included in the list of essential benefits identified in the House and Senate bills that are to be covered by the plans offered by an exchange. The level of coverage for family planning services by private plans is likely to be the topic of future discussions about the scope of benefits covered under health reform. Medicaid, in contrast, already requires that states cover family planning services, and the federal government provides an enhanced matching rate to states for these services. Under current law, about half of states have expanded their Medicaid programs to include coverage of only family planning benefits to individuals who do not quality for full Medicaid coverage. In these states, women with incomes below a certain level or who no longer qualify for Medicaid can get coverage for this narrower set of services only after the state receives special permission through a federal waiver. The House and Senate bills include a provision that would allow states to do this without having to go through the onerous process of filing for a federal waiver. It is estimated that every dollar invested in helping women avoid unintended pregnancies saves $4.02 in federal and state Medicaid expenditures.[16]

Childbirth and related conditions are the leading reasons for hospitalization in the U.S., accounting for nearly 25% of hospital stays. The Pregnancy Discrimination Act requires that employers with at least 15 employees offer plans that cover expenses for pregnancy-related conditions on the same basis as costs for other medical conditions. All state Medicaid programs cover pregnancy related care up to at least 60 days post-partum, and in fact, Medicaid now covers 41% of all births nationwide. The House and Senate plans specify that the basic benefits package of plans in an exchange must include maternity and well-baby care and increase support for nurse midwives and free-standing birth centers, as well as tobacco cessation programs for pregnant women on Medicaid. The Senate bill would also require employers with at least 50 employees to provide private space and break time to nursing mothers.

Abortion has been one of the few benefits that has been specifically debated in health reform discussions. Under current law, the federal Hyde Amendment prohibits the use of federal funds for abortion, which limits coverage under Medicaid, for federal employees, the Indian Health Service, and women in the military to only cases when the pregnancy is a result of rape or incest or is a threat to the woman's life. Both the Senate and House bills place restrictions on federal coverage of abortion, but the restrictions in the House bill are much farther reaching.[17] The most direct impact of both bills are on the plans that will be offered in the new health insurance exchanges (Figure 3). Both the House and Senate prohibit abortion coverage from being required as part of the essential benefits package. According to the House legislation, the public plan within the Exchange would be prohibited from providing coverage for abortions beyond those permitted by current federal law (to save the life of the woman or in cases of rape or incest). The House bill also prohibits federal premium credits that low-income individuals will receive from the federal

Figure 3

Health Insurance Coverage and Poverty Levels of Uninsured Women Ages 15 to 44, 2008



NOTES: Other includes programs such as Medicare and military-related coverage. The federal poverty level for a family of four in 2008 was $21,200.
SOURCE: KFF/Urban Institute analysis of 2009 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

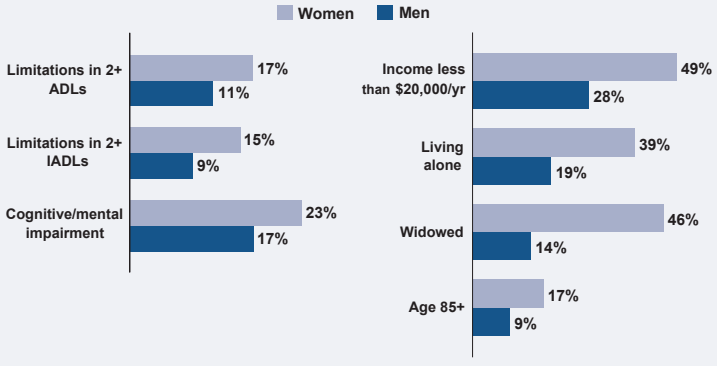
government from being used to purchase a health plan in the Exchange that includes coverage for all but federally permitted abortions. Although it is not required, private insurers may opt to offer a plan in the Exchange that covers abortions beyond those permitted by federal law. These insurers, however, will be required to also offer an identical plan that does not cover abortions for which federal funding is prohibited. Private plans participating in the Exchange may choose to offer supplemental coverage for abortions in the form of riders that are totally separate from other benefits, but that coverage must be paid for entirely with non-federal funds. Furthermore, these plans must be separately operated to assure that federal funds are not used to administer plans that cover abortions.[18]

The Senate leadership bill reiterates current law under the Hyde Amendment by specifying that federal subsidy dollars can only be used for abortions in cases where the pregnancy endangers the life of the woman or results from rape or incest. Coverage for other abortions could be paid for with private, state or local funds. The Senate bill allows the "community option" plans to cover abortions beyond the federal limits if the state chooses to do, as long as federal funds are not used to pay for the coverage. In order to ensure that federal funds are not used for abortion coverage, plans that do cover abortions beyond Hyde limitations must estimate the actuarial value of such coverage by taking into account the cost of the abortion benefit and it can cost no less than $1.00 per enrollee per month. The Senate bill also requires that Exchanges offer at least one plan that offers coverage for abortions beyond those for which federal funds are permitted as well as at least one plan that does not go beyond the federal limits.[19]

Long-term care: Women are more likely than men to both need long-term care services and lack the social supports and resources needed to live independently in the community (Figure 4). Women who are frail or have disabilities and need long-term care services often find paying for this care is expensive and can quickly exhaust lifetime savings As a result of the limited coverage for long-term care under both Medicare and private policies, many women and their families pay sizable out-of-pocket costs for nursing home and community based care. The House and Senate bills both offer some assistance with long-term care costs via the CLASS Act. This is a voluntary insurance program that would be financed by payroll deductions and that would provide at least $50 per day in cash assistance to participating individuals with disabilities and limitations to purchase support services, such as home health assistance or transportation, to help them remain independent and stay in their communities.[20] The bills state that all working adults will be automatically enrolled in the program unless they choose to opt out, and the House bill specifically requires states to assess service capacity and assure adequate infrastructure to implement the program as well as long-term services for Medicaid beneficiaries.

Figure 4

Multiple Factors Predispose Women to Needing Long-term Care



Note: ADLs refer to Activities of Daily Living (bathing, dressing, eating, walking, using the toilet, getting in and out of chairs). IADLs refer to Instrumental Activities of Daily Living (doing housework, making meals, managing money, shopping, using the telephone). Analysis excludes institutional population.

Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Access to Care file, 2006.

Federal Offices on Women's Health

Both the House and Senate bills codify the establishment of Offices on Women's Health in major federal agencies, including Department of Health and Human Services, Centers for Disease Control and Prevention, the Food and Drug Administration, Health Resources and Services Administration, and an office of Women's Health and Gender-Based Research at the Agency for Healthcare Research and Quality. These offices are designed to establish goals, provide information on women's health activities, and identify women's health priorities within their respective agencies. The bills also authorize the establishment of a Department of Health and Human

Services Coordinating Committee on Women's Health to coordinate the activities of these offices as well as a National Women's Health Information Center to facilitate exchange of information regarding health promotion, prevention, major advances in research, and other relevant developments in women's health.

While many of these offices already exist, the health reform bills offer additional protection by prohibiting termination, reorganization, or transfers of powers and responsibilities of the offices or other appointed position with primary responsibility over women's health issues without the direct approval of Congress.

Conclusion

Many steps remain before a final health reform bill could be passed, including passage of a final Senate bill, negotiations in a House-Senate conference committee, passage of a single bill by both chambers, and approval by the President. The current health reform debate offers many opportunities to improve women's access to care and coverage, ranging from insurance system reforms, to lowering out-of-pocket costs, to securing comprehensive benefits packages that address women's health needs across the course of their lives. These issues are essential in women's ability to obtain timely, appropriate care. Balancing these priorities with many other issues will be challenging, and as the process moves forward, it will be critical to keep an eye on the impact of the reform debates on women's access and coverage.

ENDNOTES

[1] Kaiser Family Foundation, *Side-by-Side Comparison of Major Health Care Reform Proposals*, 2009. www.kff.org/healthreform/sidebyside.cfm.

[2] Kaiser Family Foundation analysis of the March 2009 Current Population Survey, U.S. Bureau of the Census.

[3] Kaiser/HRET, *Employer Health Benefits Survey*, 2009, http://ehbs.kff.org/pdf/2009/7936.pdf.

[4] Kaiser Family Foundation, 2008 Kaiser Women's Health Survey, unpublished data, 2009.

[5] Kaiser Family Foundation analysis of the March 2009 Current Population Survey, U.S. Bureau of the Census.

[6] National Women's Law Center, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women*, September 2008.

[7] Ibid.

[8] Kaiser Family Foundation estimates based on March 2009 Current Population Survey, U.S. Bureau of the Census.

[9] Ibid.

[10] Kaiser Family Foundation, *Medicaid's Role for Women*, November 2007.

[11] Ibid.

[12] Kaiser Family Foundation, *Medicare's Role for Women*, 2009.

[13] S.A. 2791, Amendment to H.R. 3590. S.A. 2808 , Amendment to S.A. 2791. Congressional Record, November 30, 2009 and December 2, 2009.

[14] Kaiser Family Foundation, *Side-by-Side Comparison of Major Health Care Reform Proposals*, 2009. www.kff.org/healthreform/sidebyside.cfm.

[15] Kaiser/HRET, *Employer Health Benefits Survey*, 2003. www.kff.org/insurance/ehbs2003-2-1.cfm.

[16] Frost JJ, Finer LB, Tapales A., *Journal Health Care Poor Underserved*, 2008, 19 (3): 778-796.

[17] Kaiser Family Foundation, *Access to Abortion Coverage and Health Reform*, 2009.

[18] Rosenbaum S., et al., *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions*, November 2009.

[19] Kaiser Family Foundation, *Access to Abortion Coverage and Health Reform*, 2009.

[20] Kaiser Commission on Medicaid and the Uninsured, *The Community Living Assistance Services and Supports Act*, October 2009.

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