


Affordability Protections in Health Reform are Critical for Women

More women face cost-related challenges accessing health care than men. Seven in ten women are either uninsured or underinsured, struggling to pay a medical bill, or experiencing another cost-related problem in accessing needed care.[1] More than half (52%) of women have forgone necessary care because of cost—including not filling a prescription, skipping a medical test or failing to see a doctor when they had a medical problem—compared to 39% of men.[2]

Health care reform must make health care more affordable by controlling costs, capping out-of-pocket costs, providing subsidies for low- and moderate-income individuals and families, and prohibiting insurers from imposing annual or lifetime benefit caps. These protections are of fundamental importance to women, who have lower incomes than men on average but use and need more health care services. ***For many women and their families, health reform that assures affordability will mean the difference between accessing quality health care and going without.***

Making Health Care Affordable is Critically Important for Women

- More women are either uninsured or underinsured than men. Forty-five percent of women, compared to 39% of men, were uninsured or underinsured in 2007.[3] Women of color are considerably more likely than White women to be uninsured. In fact, millions of Latina, African American, and Native American women lack any health insurance at all—39%, 23% and 33%, respectively.[4]

- Having inadequate insurance—or no insurance at all—is particularly harmful for women, who, over the course of their lifetimes, use the health care system more than men, in part due to their reproductive health needs.[5]

- Most low-and moderate-income women struggle to afford health care. Sixty-five percent of women with incomes between $20,000 and $39,999 experienced cost-related problems accessing health care.[6]

- Women are more likely than men to experience significant financial hardship as a result of medical bills. In 2007, one-third of women, compared to one-quarter of men, were either unable to pay for food, heat or rent; had used up all of their savings; had taken out a mortgage or loan against their home; or had taken on credit card debt because of medical bills.[7]

Premium Subsidies Will Help Make Health Care Affordable for All Women

- Women and families need affordable health insurance premiums. Premiums for families have more than doubled since 1999, while workers' wages have increased by only 34 percent.[8]

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- Low-income women whose incomes are too high to qualify for Medicaid spend a disproportionate amount of their limited incomes on health insurance premiums and other out-of-pocket costs. One in three working-age women spent 10% or more of her income on health insurance premiums and out-of-pocket costs in 2007.[9]

- There are more than 14 million uninsured women (ages 18-64) with incomes below 400%FPL.[10] For a single mom with two children at 400% of poverty, the average premium cost for a Blue Cross standard policy alone would be almost 18% of her income. Sliding-scale subsidies to assist with premiums and out-of-pocket costs will help many uninsured women obtain health coverage.

Limits on Out-of-Pocket Costs Ensure that Women Aren't Forced to Forgo Necessary Care

- Limits on total out-of-pocket costs are critical to ensure that women have access to important health care services. In 2007, 62% of filed bankruptcies had a medical cause—and three-quarters of these medical debtors *had health insurance*.[11] Women were disproportionately represented among people experiencing medical debt.[12]

- Women's greater usage of prescription drugs results in disproportionately high cost-sharing responsibilities, as drug costs are a significant component of out-of-pocket expenditures.[13,14] One in four women participating in a national survey reported spending $100 or more out-of-pocket in the previous month for prescription medications, including 10% who paid at least $200.[15]

Ending Annual and Lifetime Benefit Caps Are Critical to Protect Women with Chronic Conditions and Serious Illnesses

- Prohibiting insurers from imposing annual or lifetime caps on benefits for any individual or group health insurance plan is a critically important protection that will help women afford the care they need when they need it most.

- An individual coping with a cancer diagnosis should not have to worry that her health insurance won't cover the costs of necessary treatment. Yet one in ten insured families coping with cancer reaches the limit of what their plan will pay for cancer treatment.[16]

- Even benefit limits that appear to be high can be used up quickly if a woman faces a serious condition, leaving little or no coverage for a woman's basic, unrelated health care needs. For example, a woman suffering from coronary artery disease, the leading killer of women in the U.S., could spend over one million dollars over the course of her lifetime on related treatment alone,[17] and a condition such as multiple sclerosis—which affects twice as many women as men[18]—costs an estimated $2.2 million over the course of an individual's lifetime.[19]

Health reform must ensure that health care is affordable for women and their families. Women and families need adequate premium subsidies and out-of-pocket cost limits, a prohibition on monetary benefit limits, and oversight to ensure that any limits on covered services or prescription drugs do not disproportionately impact women, who use and need such services more than men. Without these protections, too many women and families will remain without access to the affordable health care they need.

[1] Sheila D. Rustgi, Michelle M. Doty, and Sara R. Collins, *Women at Risk: Why Many Women are Forgoing Needed Health Care* (New York: The Commonwealth Fund, May 2009)
[2] *Ibid*.
[3] *Ibid*.
[4] Kaiser Family Foundation analysis of March 2006 Current Population Survey, U.S. Census Bureau, http://www.kaiseredu.org/tutorials/nonelderly/player.html.
[5] U.S. Census Bureau, Statistical Abstract of the United States: 2009: "Table 159 – Ambulatory Care Visits to Physicians' Offices and Hospital Outpatient and Emergency Departments: 2006", "Table 161 – Visits to Hospital Emergency Departments by Diagnosis: 2006," "Table 170 – Hospital Discharges and Days of Care by Selected Diagnosis: 2006," "Table 161 – Visits to Hospital Emergency Departments by Diagnosis: 2006"; U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, "Utilization of Ambulatory Medical Care by Women: United States, 1997-98," *Vital and Health Statistics*, Series 13, Number 149 (U.S. Department of Health and Human Services, Hyattsville, MD: July 2001).
[6] See *supra* note 1.
[7] *Ibid*.
[8] Kaiser Family Foundation and Health Research Education Trust, News Release, "Yearly Premiums for Family Health Coverage Risk to $12,680 in 2008, up 5 Percent, as Many Workers Also Face Higher Deductibles" (KFF/HRET, Menlo Park, CA: Sep. 24, 2008), http://www.kff.org/newsroom/ehbs092408.cfm .
[9] See *supra* note 1.
[10] National Women's Law Center calculations based on health insurance data for women ages 18-64 from the Current Population Survey's 2008 Annual Social and Economic Supplement, using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html .
[11] David Himmelstein, Deborah Thorne, Elizabeth Warren et al., Medical Bankruptcy in the United States, 2007: Results of a National Study, *The American Journal of Medicine* (pub. online June 5, 2009), http://www.amjmed.com/article/S0002-9343(09)00404-5/abstract .
[12] *Ibid*.
[13] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Women's Health USA 2008* (Rockville, Maryland: U.S. Department of Health and Human Services, 2008); U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, "Utilization of Ambulatory Medical Care by Women: United States, 1997-98," *Vital and Health Statistics*, Series 13, Number 149 (U.S. Department of Health and Human Services, Hyattsville, MD: July 2001).
[14] The Office on Women's Health, "Literature Review on Effective Sex- and Gender-Based Systems/Models for Care," (Arlington, VA: Uncommon Insights, LLC, Jan. 30, 2007), http://www.womenshealth.gov/owh/multidisciplinary/reports/GenderBasedMedicine/Question3.cfm .
[15] Salganicoff et al., The Kaiser Family Foundation, *Women and Health Care: A National Profile* (KFF, Menlo Park, CA: July 2005), http://www.kff.org/womenshealth/upload/Women-and-Health-Care-A-National-Profile-Key-Findings-from-the-Kaiser-Women-s-Health-Survey.pdf .
[16] USA Today/Kaiser Family Foundation/Harvard School of Public Health *National Survey of Households Affected by Cancer* (conducted Aug 1-Sept 14, 2006), http://www.kff.org/kaiserpolls/pomr112006pkg.cfm .
[17] Leslee J. Shaw; C. Noel Bairey Merz; Carl J. Pepine et al., The Economic Burden of Angina in Women With Suspected Ischemic Heart Disease, Circulation 114 (2006):894-904, ***http://circ.ahajournals.org/cgi/content/abstract/114/9/894?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=cardiovascular&searchid=1&FIRSTINDEX=20&resourcetype=HWFIG*** .
[18] Brigham and Women's Hospital, "Focus on Multiple Sclerosis" (April 2008), http://www.brighamandwomens.org/patient/healthmatters/multiplesclerosis.aspx.
[19] Kathryn Whetten-Goldstein, Frank A Sloan, Larry B Goldstein et al., A Comprehensive Assessment of the Cost of Multiple Sclerosis in the United States, Multiple Sclerosis 4, no. 5 (1998):419-425, ***http://msj.saqepub.com/cgi/content/abstract/4/5/419*** .