

# Women and Health Reform: An Introduction to the Issues

Health care reform is an important and personal issue for women. Each and every day, millions of women provide care in hospitals and physician offices, visit their own health care providers, or make decisions about the health care that their family members receive. Just as women's health care needs are unique, so is their relationship with the health system. Yet, our current system for financing and delivering health care does not adequately meet the needs of women. Too many women struggle to get necessary health care or go without that care altogether, and the consequences of this failure of the system can greatly damage women's health, work, and financial well-being.

As a growing number of national and state leaders make efforts to address the failing health care system, there have never been so many opportunities to ensure that women have access to the health care they need. Women's advocates can play an integral role in making sure that health reform plans address the specific health needs that women have and the unique challenges that they face in getting high-quality, comprehensive, and affordable health care.

## Why Does Health Care Reform Matter for Women?

There are a number of reasons that health reform is a women's issue:

- **Women have distinct health care needs.** Women are more likely than men to require health care throughout their lives, including regular visits to reproductive health care providers. They are more likely to have chronic conditions that require continuous health care treatment.<sup>1</sup> They also use more prescription drugs on average, and certain mental health problems affect twice as many women as men.<sup>2, 3</sup>
- **Health insurance is a critical factor in making health care accessible, but women face unique barriers to obtaining coverage that is affordable.** The relationship between health insurance coverage status and access to health care is well-documented.<sup>4</sup> Yet, 18 percent of all women in the United States are uninsured.<sup>5</sup> Even women who have insurance are more likely than men to be underinsured, with insufficient coverage that leaves them vulnerable to financial risk and unmet health needs.<sup>6</sup> Women are less likely to have access to health insurance through their own jobs and are more likely to depend on their spouse's employer-provider coverage or purchase individual market coverage directly from insurers. Coverage available through the individual market is costly and often excludes services that are essential to women's health.
- **Regardless of whether they have health insurance or not, women are more likely than men to report problems getting health care due to cost.** On average, women have lower incomes than men, and a greater share of their income is consumed by out-of-pocket health care costs.<sup>7</sup> Both insured and uninsured women are more likely to delay or avoid getting the care they need because they cannot afford it, and they are also more likely to struggle with medical debt or bills.<sup>8</sup> Health plans that do not provide comprehensive benefits or that shift more costs to women and their families will only make this situation worse.

- **Women have a major stake in decisions about health care for their entire families, and they often play a significant role in the health care that their children, spouses, or parents receive.** According to the Department of Labor, women make approximately 80 percent of all family health care decisions.<sup>9</sup> Six in ten women report that they assume primary responsibility for decisions about health insurance plans for their families.<sup>10</sup> An even greater proportion, nearly 80 percent, chooses their child's doctor.<sup>11</sup> More women than men care for a family member—most often a parent—who is chronically ill, disabled, or elderly; in this role, they typically provide assistance with medical finances such as bills or insurance paperwork in addition to making decisions about medical care.<sup>12</sup>

To address the unique health care challenges that women face, plans for health reform must create opportunities for women to obtain health insurance that meets their needs. Reforms that provide the most comprehensive benefits at the most affordable cost will go the farthest to improve women's health and financial security. Some proposals to reform the health care system, however, could actually result in higher out-of-pocket expenses, more limited benefits, and other outcomes that would be particularly harmful to women's health.

#### What Are Comprehensive Benefits?

To be comprehensive, health insurance must cover the services that women need to stay healthy and to treat physical and mental illnesses at all stages of life. Health reform plans should set a standard for health benefits that requires coverage for all necessary care, including preventive care and a full range of needed reproductive health services. This standard must incorporate maternity care as a basic health benefit rather than a separate set of services available for an additional price (sometimes called a *maternity rider*), and similarly not segregate other women's health needs for second-class treatment.

If health plans do not cover a comprehensive set of services, women may have to delay or even forgo necessary health care not reimbursed by their health plans. Some may even go into medical debt or sacrifice other basic necessities to pay for the cost of uncovered health services.

#### What Is Health Care Reform?

The phrase 'health care reform' is used broadly to describe any proposal that will change the way medical care is paid for and delivered to a population. While there is a growing consensus that change is necessary in our health care system, there is not agreement among stakeholders—including policymakers, insurance companies, employers, health care providers, and consumers—on exactly what that change should be or how it should happen. These stakeholders may, for example, have very different ideas about the best way to cover the uninsured or about the appropriate role for government in the health care system.

#### How Does Health Care Reform Happen?

**Federal vs. State Health Care Reform** Health care reform may be pursued at either the federal or the state level. Policymakers in Washington, DC and in state capitals around the country are currently exploring options for delivering better health care to all. Federal and state health care reform proposals might contain many common elements—such as an expansion of Medicaid, the joint federal-state public insurance program for low-income people—but they obviously differ in scope (i.e. state reforms will affect a much smaller

### Three Approaches to National Health Reform

Many different approaches to health reform have been introduced at the state and national levels. Over the past several years, leaders in Congress and the White House, advocacy groups, and presidential candidates have put forward various plans to change the health care system. Some would build on the current system, which involves a combination of employer-sponsored and publicly-sponsored health insurance programs. Others would drastically change the existing health system, such as through the creation of a single government-administered health insurance program. The following summaries provide three broad examples of national health reform plans that have been promoted by policymakers.

**The Single-Payer Approach** replaces existing public and private health insurance plans with a single public health plan, in which residents would automatically be enrolled. Under this approach, health care is paid for by a single entity—the government—that collects and distributes health care funds. Proponents of this approach predict much lower administrative costs than the current health care financing and delivery system. The public plan would typically be financed through an employer/employee payroll tax increase and income tax surcharge or some other revenue-generating mechanism.

Because taxes are collected from individuals and employers, the collective source of funding in the single-payer approach would be considered public. Single-payer does not necessarily denote a system of universal coverage for which everyone is eligible. While many single-payer proposals do aim for universality, by definition the single-payer approach refers only to the way care is financed and organized.

**The Hybrid Public and Private Coverage Approach**, as its name implies, incorporates a mix of public and private health insurance coverage options. It might expand public coverage programs for low-income people, maintain the role of private employer-sponsored coverage (as the majority of Americans are currently insured this way), and create a new health insurance marketplace where individuals and small businesses can choose between several different private and public health plan options.

To maintain the primary role of job-based coverage, the approach may require employers who do not provide employee health insurance to contribute to the cost of coverage (usually as a percent of payroll or per employee) through a new public insurance plan. It may also include government subsidies—typically income-related—to help low- and moderate-income families purchase coverage.

This approach could involve insurance market reforms to increase access to private coverage, including regulations that prohibit insurers from denying coverage or excluding treatment for pre-existing conditions, and rules that prevent insurers from charging people more based on factors such as age, gender, or health status.

**The Free Market Approach** involves a system in which individual consumers purchase health coverage in a free market with little government regulation, under the premise that de-regulation will increase competition among private insurance companies and therefore decrease health care costs.

This approach may include plans to reform the federal tax code by eliminating the current tax break for employer-sponsored health insurance (i.e. so that worker health benefits are reported as taxable income) and by establishing new individually-targeted tax subsidies to offset the costs of insurance, either through a standard health insurance deduction or health insurance tax credit. These tax reforms would likely bring about a shift from employer-sponsored group coverage to individual market insurance coverage.

The free market approach typically includes the privatization of public insurance programs (e.g. Medicare, Medicaid, and SCHIP) and the use of tax subsidies to encourage low-income uninsured people to purchase private coverage instead of expanding coverage through existing public programs. So-called “consumer-directed health care”—which is a combination of health plans with high deductibles and tax-sheltered health savings accounts—is also a variant of this approach.

population). There are other major differences between state and federal efforts to change the health care system:

- One difference concerns a federal law that limits how much states can regulate employer health plans, known as the Employee Retirement Income Security Act of 1974 (ERISA). ERISA was enacted to make it easier for multi-state employers to administer employee benefits like health insurance uniformly across states.

Court challenges continue to define ERISA's limits for states that seek to reform health care by regulating employer-sponsored health insurance. For example, states may face challenges if they require employers to contribute to the cost of health care for their workers. In 2006, the Fourth Circuit Court of Appeals struck down a Maryland reform law that would have required certain large employers to either contribute to employee health benefits or pay a fee to the state, ruling that the law violated ERISA.<sup>13</sup> In September 2008, however, a three-judge panel of the Ninth Circuit Court of Appeals upheld a San Francisco law that requires employers to make minimum expenditures for employee health care, either by providing benefits directly to employees or by making payments to the city's own health care program.<sup>14</sup> If employers pay the city, their employees have a choice of enrolling in the city's program, and employers do not need to provide their own benefits or alter existing employee plans.<sup>15</sup>

While the Ninth Circuit distinguished its decision from the Fourth Circuit's decision, given the likelihood of an appeal, the United States Supreme Court may ultimately decide the question of what state or local governments can and cannot do with regard to requiring employers to contribute to their workers' health care.

- A state's capacity to implement health reform is also limited by its state budget situation. Nearly every state must, by law, balance its budget each fiscal year. When states experience decreasing revenues, they typically respond by containing costs in program areas such as transportation, education, law enforcement, and health. As most health reforms require ongoing funding—and perhaps a substantial initial investment—a weak economy and a lean budget could seriously hamper reform efforts at the state level.

In the state of California, for example, a bipartisan plan for comprehensive health reform failed to gain approval of the legislature. Among the reasons for this failure were the release of a legislative analysis which projected that the plan would be more expensive than policymakers originally thought, combined with a weakening state economy and a forecasted \$14.5 billion state budget deficit.<sup>16</sup>

**Incremental vs. Comprehensive Health Care Reform.** Some health care reform proposals are *incremental*, and address just one piece of the health care landscape—for example, in 1997 Congress passed legislation to establish the State Children's Health Insurance Program, which provided affordable access to health care for millions of uninsured poor or near-poor children. Since then many states have moved to expand public health coverage for children. Though these efforts did not focus on problems in the individual insurance market or address the quality of health care, they are important steps in the struggle for comprehensive and affordable health care for all Americans.

Other reform proposals are *comprehensive*, and address several different parts of the health care system at once. Building on incremental reforms enacted throughout the 1980's and

1990's, the state of Massachusetts succeeded in passing a comprehensive plan for health reform in 2006. The Massachusetts reform plan, for instance, expanded eligibility for public insurance programs, created a health insurance exchange (called the Connector) to help individuals and small businesses enroll in private coverage, and established a statewide Racial and Ethnic Health Disparities Council to monitor disparate health outcomes among minority populations.



### **Health Care Reform Matters for Women: What Can Women's Advocates Do?**

***Women's advocates can make a strong case for health reform by using available data on the status of women's health in their state and at the national level.***

The 2007 edition of *Making the Grade on Women's Health: A National and State-by-State Report Card* (available online at <http://hrc.nwlc.org>) is the fourth in a series of reports on the current state of women's health status and various policies that affect women's health.

*Making the Grade*—which contains health status and policy indicators for women at both the national and state levels—demonstrates that the nation as a whole and many individual states are falling further behind in their quest to reach national goals for women's health. National and state-by-state report cards indicate the need for improvements in women's access to health insurance and access to health care providers and services, including critical reproductive health services.

*Making the Grade* is a useful tool for advocates who wish to highlight the need for change in the health care system. These examples of 2007 report indicators reveal some areas where progress can be made:

- The entire nation received a failing grade for the number of women without health insurance;
- The country exhibits stark ethnic and racial disparities related to health insurance coverage—for example, the proportion of uninsured Hispanic women is nearly double that of U.S. women overall;
- Most states have low Medicaid eligibility levels for working parents, with a majority covering only those at or below 74 percent of the federal poverty level (or less than \$16,000 annually for a family of four);
- Over a third of all states have weak or nonexistent policies mandating that private insurers offer all or some contraceptive coverage as a benefit in employer-sponsored insurance plans;
- Over three-quarters of states had weak or harmful policies related to whether mental health conditions would be covered under insurance plans to the same extent as physical health conditions.

These and other *Report Card* indicators point to the need for comprehensive health care reform at both the federal and state levels.

### Fitting Principles for Health Reform into a Broader Agenda to Improve Women's Lives

The National Women's Law Center's (NWLC) broad *A Platform for Progress* (August 2008) incorporates a set of basic principles for health reform, recognizing that good health is essential to a woman's well-being. Other women's advocates should consider how health reform fits into their organization's mission and vision, and adopt a set of principles that promote comprehensive health reform to improve the lives of women and their families.

#### The NWLC Platform to Guarantee Accessible, Comprehensive Health Coverage

To meet the health care needs of women and their families, health reform should ensure that our nation's health care system meets basic standards and fulfills certain principles: the system should be simple to use and understand, be sufficiently and fairly financed, and leave no one out. The system should guarantee patients a choice of doctors and health care providers, as well as the option of a publicly run health plan. There must be adequate provider reimbursement and steps taken to address provider shortages in rural and urban areas alike. In addition, health reform proposals must:

**Ensure Equity in Health Care Coverage.** Health reform must ensure there are no gaps in access to care, and work to root out disparities in health care access that currently exist. An unacceptable 18 percent of all women are uninsured, and nearly 23 percent of Black Non-Hispanic women, 35 percent of American-Indian/Native Alaskan women and 38 percent of Hispanic women are without coverage. Reform plans must ensure that care is available for patients who have diverse cultural and linguistic needs. Regardless of age, race, gender, disability, geographic location, or employment status, there must be equity in health care access, treatment, research, and resources.

**Ensure That Health Care Is Affordable for All.** Health reform should ensure that individuals, as well as businesses, have affordable and predictable health costs. Currently, more than one in four women report being unable to pay their medical bills. Health insurance premiums should not be based on factors such as gender or health status. Rather, premiums—as well as out-of-pocket health costs like copayments and deductibles—should be based on a family's ability to pay for health care.

**Ensure Comprehensive Benefits.** Health reform should ensure comprehensive coverage of health care services that people need both to stay healthy and to be treated when they are ill—regardless of the individual's stage of life. This includes coverage of preventative services; a full range of reproductive health services including abortion; treatment needed for serious and chronic diseases and conditions; and appropriate end-of-life-care.

**Build Accountability Into Any Health Care System.** Any plan for health reform should include a watchdog role for government to ensure that risk is spread fairly among all health care payers, and that health insurance companies do not improperly delay or deny coverage for health care, turn people away, establish or raise rates, or drop coverage based on a person's health history, age, or gender.

**Effectively Control Health Care Costs.** The current rate of growth in health costs is unsustainable. Between 2000 and 2006, health insurance premiums increased by 87 percent—more than four times as much as wages during that time. To address the rising cost of health care, health reform plans must adopt effective cost controls that promote quality, lower administrative costs, and provide long-term financial sustainability. Provisions should include use of standard claims forms, secure electronic medical records that adequately protect patient privacy, the use of the public's purchasing power to instill greater reliance on evidence-based protocols and lower drug and device prices, and better management and treatment of chronic diseases.

***Women's advocates can partner with other health advocacy groups in their state to work on health reform.***

Health advocacy groups exist in every state, from groups that focus on the needs of health consumers in general to those that work on health issues specific to certain populations like children or people with disabilities. Women's advocates can find out which health advocacy groups in their community are working on issues related to health reform, and partner with groups that share the goal of high-quality, comprehensive, and affordable health care for all. By coordinating their efforts, advocacy groups can reach a broader audience, use resources more effectively, and build a stronger base of support for progressive health reform.

***Women's advocates can analyze current reform efforts to determine whether they would benefit women through increased access to comprehensive, affordable, and high-quality health care.***

Armed with the knowledge of women's unique relationships with the health care system, advocates can use the *Reform Matters Toolkit* to analyze current reform proposals in their states and to make informed assessments about how these reforms would affect women.

***Women's advocates can communicate what they know about the potential impacts of various health reforms to state and national policymakers, as well as the communities they serve.***

The "Talking about Health Reform" toolkit section provides resources for helping women's advocates to spread the word about how national or state-level health reform proposals could change health care for women and their families.

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- 5 For women of color, the story is even bleaker: almost one-in-four African-American women and more than one-in-three Latinas, lack health insurance. See: National Women's Law Center, *Making the Grade on Women's Health: A National and State-by-State Report Card, 2007* (Oct. 2007), <http://hrc.nwlc.org>.
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- 12 *Id.*
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- 14 See: *Golden Gate Restaurant Ass'n v. City and Cty. of San Francisco*, No. 07-17370, 2008 WL 4401387 (9th Cir. Sep. 30, 2008).
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# Questions to Ask about Health Reform Plans

The National Women's Law Center has developed a list of questions that women's advocates can ask as they consider whether state or federal health reform proposals address women's distinct health care needs and the challenges women face in the current health care system:<sup>1</sup>

- **Does the plan expand access to ensure that health coverage is available to all?** Health insurance coverage provides women with greater access to health care and improves health outcomes. But millions of women remain uninsured and underinsured in the current health care system. Health reform plans must expand access to health coverage to all women, regardless of age, disability, geography, sexual orientation, income, health, work, or marital status. A truly inclusive health care system is one in which no one is left out.

- **Does the plan provide care that is affordable?** Women have lower incomes than men, in general, and a greater share of their income is consumed by health care costs.<sup>2</sup> Regardless of whether they have health coverage, women are more likely to delay or avoid getting the care they need because they cannot pay for it.<sup>3</sup>

Health coverage must be affordable relative to income. Moreover, affordability should be based on all the costs of a woman's health care, including her insurance premiums and out-of-pocket costs like deductibles and copayments. There should be adequate subsidies for those who are ineligible for programs like Medicaid but can't afford the total cost of their health coverage.

- **Does the plan ensure comprehensive health coverage?** Health insurance must cover the services that women need to stay healthy and to treat physical and mental illnesses at all stages of life. Health reform plans should set a standard for health benefits that require coverage for all necessary care, including preventive care and a full range of reproductive health services.

- **Does the plan adopt insurance market reforms to end unfair practices?** Women and their families are often at the mercy of insurance companies, especially if they must purchase coverage directly from the insurers through the individual insurance market. In many states, insurers can deny coverage to people with pre-existing health conditions; charge people more for their coverage because of their gender, age or health status; raise premiums significantly without oversight; refuse to cover treatment for certain conditions; and even revoke insurance policies for people who have been paying premiums for years.<sup>4</sup>

Reform proposals must end these unfair practices and promote a strong watchdog role for government to ensure that the reforms are implemented. Importantly, while state-level insurance market reforms can begin to address these problems, more than half of all people with job-based insurance are covered by health plans that are not subject to state insurance regulations. Only federal regulations will have an impact on the coverage that this sizeable population receives.<sup>5</sup>

- **Does the plan preserve or expand the role of public health insurance programs?** Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) currently provide publicly-funded health insurance for nearly 50 million women.<sup>6</sup> These public coverage programs serve as a vital health safety-net for low-income women and their families, and they must be preserved or expanded as part of any comprehensive health reform proposal.  
  
Since the majority of uninsured Americans are low-income, public coverage expansions have the potential to significantly reduce the ranks of the uninsured. Moreover, health reform proposals should establish an affordable public plan option in which anyone—regardless of income level, family, or job status—can participate. Even higher-income families and those who already have private health insurance should have the choice of purchasing coverage under a public health insurance plan.
- **What is the role of employer-sponsored health coverage?** Proposals that rely on the current system of job-based health insurance must help employers and workers alike. For example, the plan should help small or low-revenue business owners who want to provide health coverage to their employees but cannot afford the cost, and it should capture contributions from employers who don't provide health coverage. Given that more than 20 percent of uninsured women work part-time<sup>7</sup>, health reform plans should also help part-time employees and their partners or dependents access comprehensive coverage.
- **Does the plan address health disparities faced by women in minority groups, as well as those women who live in rural and underserved areas?** Access to quality health care is not equal among women. Women of color are more likely to be uninsured than their white counterparts; over a third of all Latinas lack health insurance, for instance, which is more than double the proportion of uninsured white women.<sup>8</sup> Rural communities experience higher rates of chronic disease and have poorer overall health than their urban counterparts.<sup>9</sup> Health reform plans should promote equity in health care access, treatment, research, and resources for all people in order to eliminate disparities in health outcomes and improve health and life expectancy for all.
- **Does the plan take steps to control costs, while ensuring quality care?** Health reform can only be sustainable if plans address rising health care costs without compromising the quality of health care. Plans can promote effective cost controls that will also improve care, including secure electronic medical records, an emphasis on preventive health care, greater reliance on evidence-based protocols and lower drug and device prices, and better management and treatment of chronic diseases.

Using these questions as a guide, women's advocates can use the *Reform Matters Toolkit* to analyze current reform proposals to make informed assessments about their potential impact on women, and they can support health reform that will provide high-quality, comprehensive, affordable health coverage for all.

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# Health Reform: An Opportunity to Address Health Disparities among Women

A woman's access to quality health care in the U.S. is a function of where she lives, her race and ethnicity, her family income, and her citizenship status, among other things. Millions of women experience comparatively worse health outcomes because they do not have equal access to the nation's health resources.

These health disparities are due, in large part, to differences in rates of health insurance coverage. Women of color, poor women, and women who live in rural areas, for instance, are all at greater risk of being uninsured and in turn, they suffer from higher rates of illness and unmet health needs. But some health disparities—particularly those between whites and racial or ethnic minorities—persist even when people are insured. These health disparities are a consequence of lower-quality care and problems with the way health care is delivered.

Health reform presents a unique opportunity to address the health disparities that have long troubled the U.S. health care system. Women's advocates can work to ensure that health reform proposals include measures that will make the health system more equitable, so that health disparities among women are eliminated.

## What Are Health Disparities?

Health disparities are differences in health outcomes that result from unequal distribution of or access to the resources that promote good health. Health disparities are not the result of biological risk or any other natural cause—they are the consequence of harmful public policies and unequal access to health care for certain populations.<sup>1</sup>

## Which Populations Experience Health Disparities?

Populations that experience health disparities include (but are not limited to) women of color, women who are poor, disabled women, those who live in rural areas, immigrant women, and women who identify as lesbian, gay, bisexual, or transgender (LGBT). Examples of the health disparities that exist for a few of these groups are highlighted below.

### **Women of Color**

Over the last decade, the issue of racial and ethnic health disparities, in particular, has received growing attention. In the United States, people of color are more likely to lack health insurance, receive lower-quality care, and suffer from worse health outcomes. Compared to whites, they often have poorer access to care, are more likely to receive lower-quality health care, and experience higher rates of injury, illness, and premature death.

The National Women's Law Center's 2007 edition of *Making the Grade on Women's Health: A National and State-by-State Report Card* demonstrates that the nation as a whole and many individual states are falling further behind in their quest to reach national goals for women's health. The report's findings related to racial and ethnic health disparities are particularly dismal. Consider these statistics:

- In the **United States**, nearly 86 percent of white women receive first trimester prenatal care (i.e. within the first 12 weeks), compared to just 71 percent of American Indian/Alaskan Native women.

- In **Ohio**, the average life expectancy for white women is 79 years, compared to 74 years for black women.
- In **California**, only 73 percent of Asian/Pacific Islander women received a Pap test (i.e. screening to detect cervical cancer) in the past three years, compared to 82 percent of white women.
- In **Louisiana**, the death rate for coronary heart disease is 135.5 per 100,000 for white women, compared to 191.7 per 100,000 for black women.

For more information about health disparities among women of different racial and ethnic populations, visit the interactive website for the *Making the Grade* report, at <http://hrc.nwlc.org>.

### ***Women Living in Rural Areas***

Women living in rural areas of the United States face unique barriers to accessing health care. They are more likely to be uninsured or underinsured (i.e. with health coverage that leaves them vulnerable to financial risk and/or unmet health needs).<sup>2</sup> Research demonstrates that rural residents are more likely than their urban counterparts to be self-employed or to work for small or low-revenue employers that do not offer job-based health insurance. They are also more likely to purchase coverage directly from insurers through the individual insurance market, where women face many obstacles to obtaining comprehensive and affordable coverage.<sup>3,4</sup>

Regardless of their insurance status, rural women have more trouble finding a health provider near their home. Rural residents are four times more likely to live in a medically underserved area, since health care facilities in rural parts of the country have more trouble attracting and retaining doctors, nurses, and other health providers.<sup>5</sup> Providers practicing certain specialties, such as those in the obstetrics/gynecology field, are particularly lacking in rural areas; this often presents a major barrier for rural women who need reproductive health services.

Long travel distances and limited transportation options create additional obstacles to rural women's access to health care. If a woman needs a health service that is only offered by a very limited number of providers in the area, such as reproductive or mental health care, transportation is especially problematic. For instance, a woman and her family may need to travel for hours—sometimes by multiple modes of transportation—in order to reach a pharmacy that stocks contraceptives, an abortion provider, or a mental health provider that can treat depression. Rural women and men have higher rates of chronic disease, including cancer and cardiovascular disease.<sup>6</sup> To maintain good health, it is essential that chronic diseases are well-managed, but the provider shortage and transportation issues described above make effective disease management more difficult for rural residents.

### ***Women in the LGBT Community***

Women in the lesbian, gay, bisexual, and transgender (LGBT) community experience health disparities. Research indicates that LGBT people are more likely to be uninsured and to lack a regular health provider than the general population.<sup>7</sup> Lack of formal recognition of same-sex relationships poses a major barrier to insurance coverage, as a majority of employers do not sponsor health benefits for their workers' same-sex partners as they do for married spouses. Even when they are available, domestic partner health benefits do not receive the same favorable tax treatment as other employer-provided coverage for workers' family members.<sup>8</sup>

The LGBT population is also more likely to face barriers in access to care and preventive services.<sup>9</sup> With an insufficient number of health care providers who can sufficiently treat this population—either due to outright discrimination, ignorance, or misinformation—it is often more difficult for women in the LGBT community to get comprehensive care, and they may actually be less willing to seek care if they cannot find a provider who can adequately meet their needs.<sup>10</sup> One large-scale study of health risks for older women, for instance, found that lesbian and bisexual women are significantly less likely to receive regular cancer screenings such as mammography and the Pap test.<sup>11</sup> Women of color who identify as LGBT face multiple levels of discrimination related to both racism and homophobia.<sup>12</sup> To increase rates of preventive screening and counseling among the LGBT population, the health provider workforce should be trained to provide culturally-competent care. Such training will help providers be more informed, accepting, and supportive of this population.

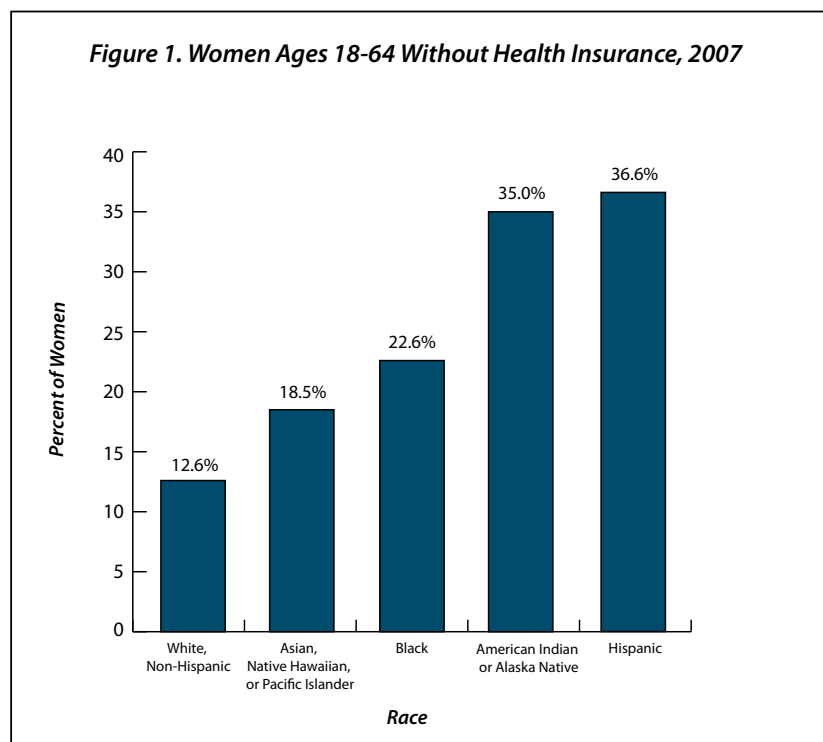
### Why Do Health Disparities Exist?

Unequal health outcomes are caused by inequities in the structure of the health system itself, including differences in access to health coverage and in the quality of health care that some populations receive. Health disparities are also influenced by a range of social and environmental determinants of health, which are typically outside the purview of health reform plans—these include access to adequate and safe housing, nutritious food, education, and transportation.

### Differences in Access to Health Coverage

Women with health insurance are more likely to seek timely preventive care, to effectively manage their chronic conditions, and to have a usual source of health care.<sup>13</sup> The relationship between coverage and positive health outcomes is well-documented. Yet women of color are considerably more likely to be uninsured than their white counterparts, as demonstrated in Figure 1. Hispanic women, for example, were roughly three times as likely as white women to be uninsured in 2007 (36.6 percent vs. 12.6 percent, respectively).

Differences in access to health coverage contribute to the persistent health disparities between racial and ethnic groups. Unequal access to health coverage is also an important factor in the health disparities that exist for people living in rural areas of the United States and for those living at or near the federal poverty level.



Source: National Women's Law Center analysis of Current Population Survey's (CPS) March 2007 Annual Social and Economic Supplement, using the U.S. Census Bureau 'CPS Table Creator,' [http://www.census.gov/hhes/www/cpstc/cps\\_table\\_creator.html](http://www.census.gov/hhes/www/cpstc/cps_table_creator.html), on August 15, 2008.

## Connecting the Dots between Health and Wealth.

In general, populations that suffer from the worst health status are also those that have the highest poverty rates. Those who have the fewest resources in the United States also report worse health outcomes, regardless of whether the measure is mortality, the prevalence of acute or chronic diseases, or untreated mental health problems.<sup>14</sup> Unsurprisingly, women in populations that experience health disparities—including women of color and those living in rural areas—are also more likely to have lower incomes.<sup>15</sup> Lower-income women are, in turn, disproportionately represented among uninsured women, who are more likely to delay or go without necessary medical care than their insured counterparts. Considering the connections between poverty, poor health, and insurance status, it is critical that health reform plans prioritize access to high-quality and **affordable** health coverage so that poverty-related health disparities are eliminated.

## Differences in Health Care Quality

Health insurance is the single most significant factor in determining an individual's access to health care. Even for people who have health coverage, however, health care delivery may be inequitable, contributing to disparate health outcomes. In a landmark 2003 report titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, a panel of scientists and doctors assembled by the Institute of Medicine (IOM) concluded that "minority patients are less likely than whites to receive the same quality of health care, even when they have similar insurance or the ability to pay for care."<sup>16</sup> Quality health care (which is discussed in

more detail elsewhere in the *Reform Matters Toolkit*) is often described as the **right care**, at the **right time**, for the **right reason**.

Indeed, there is a growing body of evidence that people of color receive lower-quality care, on average, than white people. The most recent National Healthcare Disparities Report (an annual assessment conducted by the U.S. Agency for Healthcare Research and Quality) details the range in health disparities resulting from differences in health care quality—these differences in health outcomes exist even for those who are insured. For instance:<sup>17</sup>

- In 2004, the rate of lower extremity amputations in diabetic adults was over three times higher for blacks than whites (104.0 per 1,000 compared with 27.6 per 1,000);
- In 2005 the proportion of Medicare patients with pneumonia who received recommended hospital care was lower for blacks (69.5 percent), Asians (68.7 percent), and Hispanics (66.2 percent) than for whites (74.6 percent);
- In 2004, blacks and Asians were more likely than whites to report they had poor communication with their health providers (11.3 percent for blacks and 14.3 percent for Asians compared with 9 percent for whites).

According to the IOM's *Unequal Treatment* report, inequitable health care delivery is primarily due to two sets of factors, 1) health care systems' operating environments (e.g. cultural or linguistic barriers, provider incentives to contain costs such as spending a minimal amount of time with a patient) and 2) provider uncertainty, bias, or stereotyping when treating patients of racial or ethnic minority groups.

### Strategies to Eliminate Health Disparities

As federal and state policymakers develop proposals to address myriad gaps in the current U.S. health system, they must take advantage of the important opportunity to incorporate health reform provisions that could eliminate the nation's persistent health disparities. These efforts, which are described in greater detail below, include measures to: expand affordable health insurance; improve the health care infrastructure in medically underserved communities; increase provider diversity and cultural competency; obtain the data that is necessary to document and address inequitable health outcomes; promote the medical home model; and address social and environmental determinants of health. More information about these and other reform provisions for equitable health care can be found in a 2008 report prepared by the Opportunity Agenda and Families USA, titled *Identifying and Evaluating Equity Provisions in State Health Care Reform*.

- **Expand Affordable Health Coverage.** A health system that provides high-quality, affordable health coverage for all will go a long way to eliminate the inequitable distribution of health care resources. If people of color, rural residents, and low-income people have equitable access to health insurance, they will be able to seek timely care—including preventive care—before a health problem becomes complicated and costly. Moreover, in a system where everyone has high-quality health coverage, hospitals and other health care providers have equal incentives to serve wealthy and poor communities alike.<sup>18</sup>

#### The Importance of Public Coverage Programs.

People of color are disproportionately represented in Medicaid, the health insurance program for low-income people that is jointly funded by the federal and state governments. Racial and ethnic minorities comprise about one-third of the total U.S. population but more than half of all Medicaid recipients.<sup>19</sup> Consequently, policy changes to the Medicaid program have disproportionate impacts on communities of color. Program expansions and enhancements can serve as an effective tool to improve health access and to target health disparities; at the same time, cuts and restrictions to the Medicaid program are especially harmful.

In particular, inadequate provider reimbursement is a persistent problem in the Medicaid program, which typically reimburses providers at a considerably lower rate than both private insurance companies and Medicare. This inequity contributes to health disparities. Providers will not agree to participate in Medicaid if reimbursement rates are too low, which makes it more difficult for Medicaid enrollees to find health providers when they need care. States have the authority to increase these rates, which has the potential to reduce health disparities.<sup>20</sup>

- **Improve the Health Infrastructure.** Communities that are predominantly minority, as well as those that are located in rural areas, have fewer health care resources such as hospitals, primary care providers, outpatient clinics, and nursing home facilities.<sup>21</sup> States must continue to direct resources and incentives to improve provider availability in these underserved areas, and they must support new initiatives for correcting the imbalance of health resources. These initiatives include graduate medical education programs that focus on medically underserved areas, as well as loan forgiveness or

scholarship programs that require service in such areas. Safety-net hospitals and other providers (i.e. those that serve a high proportion of uninsured, publicly-insured, and other underserved communities) serve as critical links to health services for many communities of color, and reform plans can ensure that these institutions receive adequate financial support from the government so that they are not financially vulnerable.

- **Increase Provider Diversity.** Increasing the number of minority health care providers has proven effective in improving the quality of care delivered to racial and ethnic minorities.<sup>22</sup> Health care providers of color, for instance, are more likely to work in minority or underserved communities, therefore increasing the availability of health resources in those communities. Minority populations are also more likely to report satisfaction with care delivered by racially diverse providers.<sup>23</sup> Yet these types of providers are under-represented in the health care workforce. In 2004, for example, over 80 percent of registered nurses in the United States were white.
- **Promote Cultural Competency.** It is equally important that federal and state reform initiatives promote cultural competency among health care providers. For example, in a recent study that found unequal health outcomes for black and white diabetes patients treated by the same doctor, authors concluded that such disparities do not result from overt racism, but rather a “systemic failure to tailor treatments to patients’ cultural norms.”<sup>24</sup> They recommended basic cultural competency for diabetes management—that is, that health providers learn more about treating minority communities and tailor strategies for educating minority patients about managing a chronic disease.

By improving provider-patient communication and supporting the delivery of care that accommodates patients’ cultural factors, training in culturally-competent medicine can eliminate racial and ethnic health disparities. Ensuring that patients with Limited English Proficiency (LEP)—including those in the immigrant community—have access to accurately translated health-related materials that they can comprehend (sometimes referred to as linguistic competence) is another important component of delivering culturally-competent care.

- **Collect the Right Data to Document and Address Health Disparities.** Without accurate and complete data on health consumer demographics—including language status, race/ethnicity, sexual orientation, and income—and the different health outcomes that these consumers experience, it will be impossible to fully address health disparities. For public and private health systems to have the ability to monitor racial and ethnic, language status, and income-based health care disparities, federal and state governments must support the collection and regular analysis of disparity data, measured both in terms of health care access and quality.<sup>25</sup>
- **Promote the “Medical Home” Model.** A “medical home” (sometimes called a “health care home”) generally refers to a centralized location for health care, with one personal health care provider who coordinates an individual’s care. This personal provider is responsible for all of a patient’s health care needs, including appropriately arranging care with other health professionals. Public and private health insurers have implemented medical home initiatives as strategies to improve health care quality and safety, and research demonstrates that when minorities have a medical home, their access to preventive care improves substantially (e.g. about two-thirds of all adults

who have a medical home receive preventive care reminders). Similar (and significant) proportions of white, black, and Hispanic Americans with medical homes report getting the care they need when they need it, indicating that these initiatives have the potential to reduce or even eliminate racial and ethnic disparities in access to care.<sup>26</sup>

- **Address the Environmental and Social Determinants of Health.** Disparate health outcomes are not solely a product of inequities in the health system. Unequal access to other resources in a woman's social and physical environment may also have a negative impact on her health. Poor housing conditions, a dearth of safe public spaces for outdoor activities, and a scarcity of grocery stores selling fresh fruits and vegetables, for example, can all contribute to poorer health outcomes among people living in minority communities. Some of the solutions to these problems are admittedly beyond the scope of even a very comprehensive health reform plan. But, health reform plans may incorporate community-level interventions that address multiple determinants of health—social, environmental, and health-related factors—as a starting point for incorporating these important issues into health reform. Community interventions supported through grant programs of the Center for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH 2010) and the Department of Health and Human Services' Office of Minority Health have effectively reduced racial and ethnic disparities in targeted subpopulations. These interventions—which include efforts to organize communities, provide mass and one-on-one health education, conduct screenings for risk factors, and reduce environment risk factors through local program and policy change—can improve overall quality of life for minority groups.<sup>27</sup>

### Lessons from the States:

#### Statewide Councils on Health Disparities.

As an initial step to implementing reforms that would address unequal health outcomes among their residents, many states have created special entities expressly for the purpose of tackling health disparities. At least 35 states have taken such steps, including:<sup>28</sup>

- **Massachusetts:** As part of its broad 2006 health reform package, the state established the Health Disparities Council, charged with developing recommendations on several minority health issues including workforce diversity, disparate disease rates among communities of color, and social determinants of health.<sup>29</sup>
- **Pennsylvania:** The Office of Health Equity, established in April 2006 within the state's Department of Health, collaborates with state agencies, academic institutions and community groups to improve the health status of groups experiencing health disparities. The office does not limit its work to health disparities among racial and ethnic minorities, but also focuses on disparities in geographic areas and among socioeconomic groups.<sup>30</sup>
- **Washington:** In 2006, the state legislature created the Governor's Interagency Coordinating Council on Health Disparities. This council is charged with creating an action plan to address the contributing factors of health that can have broad impacts on improving health status, health literacy, physical activity, and nutrition.<sup>31</sup>



## What Can Women's Advocates Do to Ensure That Health Reform Addresses Health Disparities?

***Women's advocates should inquire how health reform plans will affect populations that experience health disparities.***

Advocates must determine whether and how health reform proposals may differentially affect women of color, low-income populations, and other underserved groups that experience health disparities. Health reform plans that expand health insurance coverage but do nothing to improve provider availability, for example, may hold little benefit for women who live in rural areas with severe health provider shortages. Plans that enhance and sustain the Medicaid program, on the other hand, will have a positive impact on the health of communities of color and low-income populations, since these groups are particularly dependent on Medicaid for their care.

***Women's advocates can promote health reform measures that explicitly address health disparities.***

Health reform presents a unique and important opportunity to incorporate initiatives that could eliminate the nation's persistent health disparities. These include efforts to expand affordable health insurance; improve the health care infrastructure in medically underserved communities; increase provider diversity and cultural competency; obtain the data that is necessary to document and address inequitable health outcomes; promote the medical home model; and address social and environmental determinants of health.

***Women's advocates can partner with groups that represent or serve groups that experience health disparities.***

Many organizations are working at both the national and state level to address health issues that specifically affect those women most likely to experience health disparities, including women of color, rural women, women living in poverty, and women in the LGBT community. By joining forces with these groups, advocates for health reform can ensure that their work incorporates the interests of women who experience health disparities, and ultimately promote health reform plans that correct inequities in the health care system.



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Brian Smedley, et al., The Commonwealth Fund, *Identifying and Evaluating Equity Provisions in State Health Care Reform* (Apr. 2008), [http://www.commonwealthfund.org/usr\\_doc/Smedley\\_identifyingequityprovisions\\_1124.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Smedley_identifyingequityprovisions_1124.pdf?section=4039)

"Unnatural Causes: Is Inequality Making Us Sick": This seven-part documentary series on health inequalities, which aired on PBS, is available (with supporting materials) at [www.unnaturalcauses.org](http://www.unnaturalcauses.org)

The Rural Women's Health Project, <http://www.rwhp.org/>

The National Coalition for LGBT Health, <http://www.lgbthealth.net/>

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## WOMEN AND HEALTH COVERAGE: A FRAMEWORK FOR MOVING FORWARD

by

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### INTRODUCTION AND EXECUTIVE SUMMARY

Health care coverage is back in the spotlight, in the wake of growing costs and increasing numbers of uninsured individuals. Public opinion polls show that the majority of all Americans, and women in particular, believe that addressing health care issues should be one of the nation's top priorities.

Currently, there are 44.8 million Americans without health insurance.<sup>1</sup> And though women are more likely than men to have health coverage, both insured and uninsured women are more likely than men to report difficulty obtaining health care because of cost.

The Commonwealth Fund and the National Women's Law Center have jointly authored an issue brief entitled *Women and Health Coverage: The Affordability Gap*, which explores the difficulties women face in obtaining and affording health insurance. The National Women's Law Center's companion issue brief, *Women and Health Coverage: A Framework for Moving Forward*, evaluates efforts to expand health insurance in terms of their potential to address the particular challenges women face. Together these briefs demonstrate that the unmet health needs of women in this country are great, that reforms can be designed to meet the needs of women and that there is great variation among the proposals on the table with respect to their ability to meet women's needs.

### THE AFFORDABILITY GAP

This issue brief demonstrates that health care affordability is a particular problem for women. They are more likely to need and use health services, but on average have lower incomes than men and therefore less financial ability to pay for their greater health care needs. At the same time, many women's health insurance coverage is precarious and incomplete. They are less likely to have insurance from their own employer and, regardless of what kind of coverage they have, they are more likely to have to make substantial out-of-pocket payments.

Highlights from *Women and Health Coverage: The Affordability Gap* show that there are several coverage patterns unique to women:

- **Almost as many women are uninsured all year as are uninsured for part of the year.** While 44.8 million people have no insurance for a whole year, many

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millions more people are uninsured for months at a time. One in four women are either uninsured for part or all of the year.

- **Women have less access to their own employer-sponsored insurance.** Thirty-five percent of uninsured women are not employed, compared to only 18% of uninsured men. While all part-time workers are less likely to be insured, only 13% of uninsured men work part-time while 22% of uninsured women work part-time.
- **Women are more likely to depend on their spouses for their insurance and therefore face more instability in their coverage.** Twenty-four percent of women get their insurance through their spouse's job, as compared to only 11% of men. Dependent coverage is not a stable source of insurance; in fact, between 2001 and 2005, employers dropping such coverage accounted for 11% of the decline in employer-sponsored insurance overall.<sup>2</sup>
- **More women than men purchase insurance in the individual market, which is more expensive than insurance in the group market.** Slightly more women than men purchase insurance in the individual market.<sup>3</sup> People who purchase individual health insurance do so because they have few alternatives, and yet those who have a greater need for health insurance face barriers in purchasing individual insurance coverage because they can be denied coverage altogether or charged extremely high rates.

Women face difficulty in affording care.

- **Women are more likely to have lower incomes than men.** Women are more likely to be poor. Seventeen percent of women ages 19-64 are below 100% of federal poverty level (FPL) compared to 13% of men in that age group.
- **Women use more health care services on average than men.** Women's reproductive health needs require them to get regular check-ups, whether or not they have children. Moreover, women of all ages are more likely than men to take prescription medications on a regular basis (60% versus 44%).
- **Women have higher out-of-pocket costs than men as a share of their income.** Although women have less income than men, women have more health care needs and use more services. Sixteen percent (16%) of all insured women, in contrast to 9% of all insured men, have high medical costs compared to their income and, therefore, are considered "underinsured."
- **Women are more likely to avoid needed health care because of cost.** Overall, women are more likely than men to have difficulty obtaining needed health care (43% vs. 30%)—a difference more pronounced for uninsured women (68% vs. 49%). Women are more likely than men to not see a doctor or specialist, fill a prescription, or get a medical test or treatment when needed.
- **Women are more likely to have medical bill and debt problems.** Among the uninsured, 56% of women report difficulty paying bills compared to 48% of men. Twenty-six percent of women compared to 19% of men were not able to pay their medical bills.

## A FRAMEWORK FOR MOVING FORWARD

The facts demonstrate that women often fall through the cracks entirely in the current system or obtain coverage that is inadequate for their needs. With so many barriers to comprehensive and affordable health care, improvements are clearly necessary. Whether health care coverage reforms are incremental and build on the current health care system or create a new single universal health care system for all, the same issues of affordability and comprehensiveness of benefits must be addressed.

Coverage that is both affordable and comprehensive can be achieved in a number of ways. It is possible, for example,

to combine employer-sponsored coverage and public programs, or to create a new system that covers all individuals with the same plan. There are several characteristics in any plan, however, that are essential to meet the needs of the American public, and most especially women.

Regardless of what form expansion efforts take, the following questions must be asked to determine which policies would have the most positive far reaching effects for women. Does the policy:

- ✓ Assure that all individuals have coverage?
- ✓ Extend coverage to the uninsured without eroding the coverage of the insured?
- ✓ Utilize large groups so that the risk to any one individual is minimized?
- ✓ If building on employer-sponsored coverage, ensure that all employees, including part-time employees, and dependents have access to coverage?
- ✓ Enable individuals who are outside the labor force to obtain coverage?
- ✓ Provide subsidies to ensure that low-income individuals can afford health coverage?
- ✓ Ensure that health plans provide comprehensive benefits, including services that women need?
- ✓ Ensure that the out-of-pocket costs (e.g. co-payments and deductibles) are affordable relative to the individual's income?

Because the impact of proposals on women varies dramatically, these questions can serve as a tool to determine which policies would be most beneficial for them. A policy such as expanding Medicaid to cover more low-income parents would provide the especially needy women who qualify with coverage that is comprehensive and affordable, as the program's cost-sharing requirements are appropriately minimal given the low income of this population. To reach an additional set of women, a policy that allows businesses and individuals to buy into an existing large pool of insured individuals, such the Federal Employees Health Benefits Program (FEHBP), could provide affordable coverage because individuals would share the risk of their health costs with a large group of people, thereby keeping the cost of each person's premiums down. This plan could be designed to work more beneficially for women, given their lower incomes on average than men, by using sliding scale subsidies for premium costs and providing a range of benefits and cost-sharing plans. Furthermore, a universal single-payer system based on Medicare could be designed to ensure that all women have comprehensive and affordable coverage. Benefits would have to include the range of services that women need, like cancer screenings and maternity coverage, and cost-sharing requirements would have to be appropriate relative to women's incomes, in order to be most effective.

Conversely, answering the questions listed above would point out the weaknesses of other proposals under consideration. For example, offering tax credits to encourage women to buy into the individual market would not help very many women because such plans are expensive to purchase, even with the help of a tax credit, and usually have limited benefits and high cost-sharing requirements. Most women would incur large costs for their care, even if they were able to buy the coverage. Additionally, this type of approach could result in some women losing their employer-sponsored coverage because some employers would drop coverage for their employees if tax credits were made available to them.

As the review of the proposals below demonstrates, there are a number of particularly promising approaches that make the provision of health coverage for all an achievable goal. Policymakers should seize the opportunity presented by the public's need and demand for change to eliminate coverage gaps and provide comprehensive health coverage. With the number of uninsured and underinsured people growing annually, now is the time to implement policies that truly meet the needs of both women and men in this country.

## COVERAGE EXPANSION POLICIES AND THEIR EFFECTS ON WOMEN

With so many barriers to comprehensive and affordable health care, improvements are clearly necessary, though many questions remain as to how to achieve reform. The following analyzes a large range of health coverage expansion proposals, from newly created universal coverage plans to incremental proposals that affect a smaller number of people. Each policy is described and then analyzed for its effect on coverage generally and for its specific effect on women.

### EXPANDING HEALTH COVERAGE: EMPLOYER-SPONSORED HEALTH INSURANCE

One approach targets the expansion of employer-sponsored health insurance (ESI), the most common type of private health insurance in this country. Employers usually have a cross-section of employees of varying age and health status, which allows for the health risks of the employees to be “pooled” across the whole group. A number of proposals seek to encourage or require employers to offer coverage to their employees. However, none of them requires all employees to receive benefits, and consequently, most only help full-time employees. Given that many of the uninsured, particularly women, work part-time, policies that target employers but do not require the inclusion of part-time workers will not be as beneficial as they could be in lowering the number of uninsured workers.<sup>4</sup> In addition, employer coverage has been declining, especially for dependents, putting women at particular risk. Proposals targeting ESI include:

#### *Association Health Plans*

**Policy:** Some proposals focus on the types of employers that often do not offer coverage today, such as small businesses. Those that do, on average, offer fewer health benefits and require higher cost-sharing than larger firms.<sup>5</sup> On the state level, these proposals allow small businesses to band together at their choosing and create purchasing coalitions within a state. These coalitions give small employers the advantages of large ones, namely increased purchasing power, lower administrative costs and greater choice of plans for employees. At the federal level, there is an initiative that would create purchasing coalitions, known as Association Health Plans (AHPs). AHPs could buy insurance from insurance companies or become insurers themselves by paying claims from their own funds.<sup>6</sup> As they have been currently designed, AHPs are subject only to very minimal federal regulations. They could offer insurance across state lines and be exempted from state insurance regulations, which generally include comprehensive consumer protections and important benefit mandates.

**Effects on Coverage:** Because AHPs might help lower rates for small businesses, this approach could help more people secure access to insurance. Since they are not subject to state regulations, they are likely to result in benefit packages that are not comprehensive and therefore result in high out-of-pocket costs for the individual employee. If benefit mandates and consumer protections in the small group market did apply to AHPs, this approach would be more beneficial for employees.

**Effects on Women's Coverage:** For women working in small businesses who are relatively healthy, AHPs may create insurance options that previously did not exist. However, AHPs do not have to accept all businesses, so companies with more women, who use more services, or with sicker individuals may be left out or charged unaffordable premiums. Finally, because AHPs are exempt from state benefit mandates and other consumer protections, women, who are the primary beneficiaries of laws that, for example, require coverage of maternity care or breast cancer treatment, would be disproportionately affected.

#### *Buying into the Federal Employee Health Benefits Program*

**Policy:** This policy option would allow small businesses or individuals to buy into the Federal Employee Health Benefits Program (FEHBP), the health plan the federal government provides its employees.<sup>7</sup> Generally, such proposals require insurers that offer coverage through FEHBP to do so for eligible individuals (i.e., the pool is built

on, but not mixed with, the existing FEHBP pool). A variation on this proposal provides small businesses, particularly those with a large proportion of low-income workers, a subsidy to help them to buy into the program for their employees.

**Effects on Coverage:** This policy would provide comprehensive insurance to individuals who, on their own or through their employer, could afford to buy into the FEHBP. Some opponents, however, believe that allowing broad buy-in to FEHBP would undercut the entire program because too many sick people would enter the system, thereby resulting in higher premiums for all participants.<sup>8</sup> To prevent higher premiums for current FEHBP participants, a parallel program would have to be created, although the pool would include, on average, sicker people, thereby resulting in more expensive premiums for its participants.

**Effects on Women's Coverage:** This approach, like AHPs, would give women greater access to employer-based coverage. They would likely have a greater choice of plans than offered through traditional ESI and AHPs since FEHBP's size attracts a number of large health plans. However, subsidies for small businesses with low-income women would need to be substantial to make coverage affordable.

### Requiring Employers to Provide Coverage

**Policy:** Some states have promoted access to ESI by directly requiring an employer to provide health coverage for their workers or pay a fee to the state as a penalty so that their employees can be covered by public insurance.<sup>9</sup> This approach has been considered and/or passed in several states.<sup>10</sup> For example, Maryland passed a law in 2006 which required businesses with more than 10,000 employees in the state to spend at least 8% of their payroll on employee health benefits or pay into a fund for the uninsured. This law was subsequently struck down by a federal court and is currently on appeal. Similarly, Vermont passed a law to require employers to pay an annual assessment for each full-time equivalent employee if the company does not offer insurance to its employees. (See Appendix Table A.)

**Effects on Coverage:** This approach, if applied broadly to all employers in a state, could have the practical effect of providing access to all workers. However, given that recent proposals and laws limit the requirement to large employers, individuals working in small businesses, who are less likely to have access to ESI, will not benefit.

**Effects on Women's Coverage:** Requiring employers to provide coverage helps women who themselves are employed or whose spouses are employed but are not receiving ESI. However, unless the employer's contribution is substantial, the newly available insurance may not be affordable for women as employees. In addition, a larger fraction of women than men do not work. If these women are not eligible for coverage as a dependent, or that dependent coverage is not affordable, then they will be left out of the system.

### COBRA coverage expansions

**Policy:** Under federal law, most employers that provide ESI and have 20 or more employees must offer employees and their families the option of continuing the insurance at group rates when faced with the loss of coverage because of certain events.<sup>11</sup> The length of coverage depends on the event (e.g. if the event is death of or divorce from the worker, 36 months of coverage for the worker's beneficiary is required). Employers may charge employees or family members 102% of the otherwise applicable premium. States can go beyond the federal law and extend the amount of time employees qualify for COBRA because of specific events such as divorce. Specifically, policies extend COBRA to older people at pre-Medicare age so as to provide coverage to individuals until they become eligible for Medicare at age 65 or are covered by another insurance plan. (See Appendix Table A.)

**Effects on Coverage:** COBRA has proven itself to be an important means for keeping people insured during

periods of unemployment. Any policy that extends the scope of COBRA therefore benefits uninsured workers and their families. This is especially true of those that have a history of health problems or high health care needs, since the pooled premium of COBRA will be less expensive than the individual market and access is guaranteed. However, one of the main reasons cited for not continuing coverage through COBRA is cost.<sup>12</sup> Therefore, although this policy option does make insurance available, it does not address affordability.

**Effects on Women's Coverage:** Policies that extend the amount of time employees and their dependents qualify for COBRA would be beneficial to women, specifically for older and/or divorced women as well as those with high costs or risks. Given that women are more likely to rely on a spouse's ESI, extending this COBRA option would help women remain insured, if they can afford the premium,<sup>13</sup> until they are old enough to qualify for Medicare.

### Health Savings Accounts

**Policy:** Another approach to making health coverage available is the creation of Health Savings Accounts (HSAs). Federal tax benefits are provided to HSAs, which are specific accounts funded by the employer and/or employee to be used by the employee to purchase health services. These accounts are designed to be combined with a health plan that has a high deductible.<sup>14</sup> Employers can offer HSAs as the only form of coverage for their employees or they can be provided as an alternative for an employee to participating in the comprehensive ESI plan. Employers may favor these accounts<sup>15</sup> because premiums for high-deductible plans are less than premiums for comprehensive coverage. Proponents of HSAs would like to see further tax benefits created in order to promote the use of these accounts and expand their scope to reach individuals in other insurance markets. In fact, these accounts, often referred to as "consumer directed arrangements" can be used in some form for all types of coverage, including the individual market<sup>16</sup> and Medicare and Medicaid.

**Effects on Coverage:** Because the funds in the HSAs belong to the individual, they are portable and remain with the individual to be used to cover their medical expenses, regardless of whether he or she changes employers or the new employer offers HSAs.<sup>17</sup> However, people with less income to contribute to the HSA may not have enough funds in their accounts to cover their health care needs in a given year. Also, depending on the design of the high-deductible plan, there may be holes in coverage that will require individuals to pay substantial out-of-pocket costs until they meet the high deductible and the plan begins reimbursing for services. While the main goal of an HSA is to discourage the overuse of services, increased cost-sharing has been shown to lead to the under use of needed services, particularly for those with low incomes and those with chronic illnesses.<sup>18</sup> In fact, a recent examination of early experiences with HSAs has also shown that such accounts tend to primarily benefit individuals with higher incomes and in good overall health.<sup>19</sup>

**Effects on Women's Coverage:** The fact that HSAs are portable benefits women in particular as they are more likely than men to cycle in and out of the labor force. However, women with less disposable income and/or higher health care needs are less well-served by an HSA than a comprehensive ESI plan primarily, because they will face higher out-of-pocket payments from the high-deductible plan and are less likely to be able to cover the difference through their tax savings. Because women typically need and use more health care than men, high out-of-pocket costs can discourage needed health care use for women. Additionally, women may be less likely to use preventive services—key to early detection and treatment of disease—if faced with high cost-sharing.

## EXPANDING HEALTH COVERAGE: THE INDIVIDUAL INSURANCE MARKET

A second approach is to expand the individual insurance market. Proponents of this approach argue that ESI, by linking insurance to work, encourages "job lock," preventing people from changing jobs or work status for fear of losing coverage. And, as discussed above, ESI is less accessible for certain groups, such as those who work part-time or are self-employed. Moreover, in the individual market, eligibility and initial premiums are usually based on the individual's health status and risk characteristics, thereby making coverage difficult to obtain or very expensive if the

person has any negative medical history. Also, plans in this market often offer only minimal benefits and high cost-sharing. Changes to the individual market include:

### *Tax Credits for the Individual Market*

**Policy:** One prominent proposal for increasing affordability of health coverage provides tax credits to individuals that they can use to purchase health insurance in the individual market. These credits, which would be available to those who do not have access to ESI or public programs, would total up to \$1,000 for individuals and \$2,000 for families. They would be phased out for middle-income people.<sup>20</sup> Also, most proposals make the tax credit refundable, which would benefit individuals whose incomes are low enough that they do not pay income taxes.

**Effects on Coverage:** Given that the individual market can be expensive, this tax credit would help to make individual insurance more affordable. However, individual insurance is often unavailable because even minor conditions can be grounds for denial of coverage. There is also potential that job-based health insurance will become less affordable as a consequence of this policy.<sup>21</sup>

**Effects on Women's Coverage:** Studies have found that low-income women would face extraordinary difficulties in securing affordable health coverage in the individual insurance market even if assisted by tax credits of a \$1,000 a year.<sup>22</sup> Women are usually quoted higher premium rates than men and if maternity coverage is needed, the premiums are even higher.<sup>23</sup> Another common problem for women in this market is underinsurance. Women face high out-of-pocket costs as plans often contain carve-outs for maternity coverage, caps on prescription drugs and limitations or exclusions of certain kinds of services, such as mental health.

### *Regulations for the Individual Market*

**Policy:** States can enact protections for people seeking to buy insurance in the individual market. The two most common regulations require that plans be sold on a “guaranteed issue” basis, which provides access to coverage for all applicants regardless of health status, or through “rating restrictions,” which limit the amount a premium can vary based on gender, age or health status.<sup>24</sup> (See *Appendix Table B*.)

**Effects on Coverage:** Both of these approaches would make individual plans accessible to high-risk populations, including moderate-income, chronically-ill individuals who might otherwise not be able to afford the premiums. However, out-of-pocket costs in the individual market would still be high compared to those associated with employer coverage. There is also evidence to suggest that such regulations in the individual market lead to increased costs for healthy applicants.<sup>25</sup>

**Effects on Women's Coverage:** Given that women are more likely to be low-income and have chronic illnesses, while these regulations would help some women gain access to health coverage on the individual market, high premiums would remain a barrier for many women. In addition, while women could gain insurance, they may be underinsured, still paying a large fraction of income on health care, and lacking coverage for critical services.

### *Tax Deductions to Encourage People to Purchase Individual Insurance*

**Policy:** This proposal would allow any taxpayer who obtains qualifying health insurance<sup>26</sup> to receive a standard deduction of \$15,000 for a family and \$7,500 for an individual. The deduction would be allowed regardless of the costs of health insurance policy and whether the insurance plan was purchased through an employer or on the individual market.<sup>27</sup>

**Effects on Coverage:** This proposal would primarily help those already purchasing coverage through the individual market as it would reduce taxes for this group. But the proposal does not help make individual coverage more affordable to those who currently cannot access it, due to either low-income or health conditions. Because the proposal is a tax deduction rather than a tax credit, it would only help those individuals who earn enough to pay

taxes. Given that over half of the uninsured have no tax liability, this proposal would not help them. Another concern is the effect such a policy could have on ESI. Because the deduction is a set amount and is not indexed to rise with health care costs, over time, more workers would be required to pay taxes on benefits that exceed the limited deduction. This limited deduction could lead employers to cap their contributions to employee health benefits and offer less comprehensive plans.

**Effects on Women's Coverage:** This policy will not help those women who lack ESI obtain comprehensive coverage in the individual market. Given that women's incomes tend to be lower than men's, women will be less likely to benefit from a tax deduction than they would from a tax credit and even less likely to benefit enough to afford an individual health plan. Furthermore, the potential impacts on the employer-sponsored system could also affect the comprehensiveness of ESI which would negatively impact women.

## EXPANDING HEALTH COVERAGE: PUBLIC PROGRAMS

The third approach is to expand public programs to cover more people. Currently, public insurance is limited to those that meet certain state and federal requirements. For example, the Medicaid program reaches select populations (i.e. children, pregnant women, parents of dependent children, elderly and people with disabilities) at specified and typically very low income levels. Medicare is restricted to the elderly and certain people with disabilities. These rules could be changed. However, since both types of coverage come with larger government subsidies than is available in ESI and the individual market, budget costs tend to raise concerns among policymakers. Proposals to expand public programs include:

### Extending Medicaid to Low-Income Parents

**Policy:** Expanding the eligibility for Medicaid could insure a large fraction of low-income families,<sup>28</sup> nearly half of whom are uninsured. States can raise the income eligibility level for low-income parents, which in most states is well below the eligibility level for children.<sup>29</sup> To encourage states to insure more low-income parents, the federal government could increase federal funding to states for this purpose. (*See Appendix Table C.*)

**Effects on Coverage:** Allowing parents to qualify for Medicaid along with their children would improve insurance rates for low-income families. Research shows that Medicaid coverage is essential not only to the health of parents but also to the health of their children, who are more likely to be enrolled and get services if their parents are also enrolled.<sup>30</sup> Unfortunately, a new federal law, the Deficit Reduction Act of 2005, has given states the ability to make significant changes in Medicaid benefit packages and cost-sharing requirements, which could affect the comprehensiveness and affordability of Medicaid coverage.

**Effects on Women's Coverage:** A quarter of uninsured women are mothers whose income is low enough that their children are eligible for Medicaid or SCHIP,<sup>31</sup> although they themselves do not qualify. Medicaid, therefore, can play an important role for women, who are more likely to be the custodial parent. In particular, extending Medicaid to cover more low-income parents would reach many low-income women who are working. It would also reach women who would otherwise not be helped by policies that use the tax code to provide subsidies, given that such policies leave a significant premium to be paid by the individual. Finally, Medicaid protects women from high out-of-pocket costs by limiting the amount of co-payments that beneficiaries can be charged. However, because states would have to decide whether to take this option, coverage would depend on where a woman lives, perpetuating the variability that occurs in today's Medicaid program. In addition, this policy may be viewed as unfair since it targets higher-income women with dependents rather than lower-income women without them.

### Public Insurance for Adults Without Children

**Policy:** Adults without children comprise a high percentage of the uninsured partly because federal law does not allow Medicaid coverage for non-disabled adults under age 65 who do not have children. To expand coverage to

this population, states must secure a budget-neutral waiver of federal law or provide coverage using only state funds. States could address these gaps by creating a publicly-funded health insurance option for uninsured low-income adults regardless of their parental status, age or disability. In addition, Congress could make covering this population a new state option and, to encourage states' use of the option, increase its matching payments for it.

*(See Appendix Table C.)*

**Effects on Coverage:** This policy would help insure low-income individuals who do not have families. Because Medicaid tends to have comprehensive benefits, access to services would be largely guaranteed. However, low-income non-disabled adults without children are often low on the priority list for public money and the programs they fund.

**Effects on Women's Coverage:** This policy would insure the poorest women in the nation who have a high rate of uninsurance. It also helps those who are no longer eligible for Medicaid (as their children are no longer "dependents") and yet are still not old enough to qualify for Medicare in their own right.

### *Creating Medicare Buy-in for Uninsured ages 55 to 65*

**Policy:** To cover the rising number of uninsured older Americans, the federal government could allow people ages 55 to 65 to buy into Medicare by paying a premium. Proposals differ in their eligibility rules within this age group as well as the amount of premium assistance that would be provided for lower-income, older adults.

**Effects on Coverage:** Older uninsured adults are particularly vulnerable to health problems yet are less likely to have access to job-based health insurance or be able to afford the high premiums they face in the individual market. Therefore, creating an option for older people to obtain comprehensive coverage could insure many vulnerable individuals. There is concern, however, similar to FEHBP buy-in programs, that because more people in poor health would join the pool, such an option would raise the premiums for all participants. In addition, Medicare's benefits are less than FEHBP's in some areas (e.g., mental health coverage).

**Effects on Women's Coverage:** Given that both age and gender are taken into account when premiums are determined on the individual market, older women face much higher costs than the general population in securing such coverage. Allowing beneficiaries buy in to Medicare before age 65 is an affordable option for women, as a high proportion of 50 to 64 year old women whose husbands are on Medicare are themselves uninsured.<sup>32</sup> It could also create continuity in coverage, since Medicare will become this age group's primary insurer after they become 65. However, depending on what premiums are charged, affordability might still be a barrier.

## MAKING COVERAGE UNIVERSAL

Each of the aforementioned incremental policy proposals targets a subsection of people lacking affordable and comprehensive insurance. However, designing a new universal health system from the ground up could be the best way to provide for the health care needs of all women and men. In order to reach everyone, a universal approach must either completely redesign our health care system, or combine several incremental policy options. Proposals that make coverage universal include:

### *Creating a New System Based on Medicare or the Individual Market*

**Policy:** A number of proposals assume that our system is broken beyond repair and needs to be simplified as well as expanded for all people. Each proposal could be designed in such a way as to be affordable for all, assuming the appropriate level of financial commitment from the federal government would be forthcoming. In addition, they could, through regulation or insurance pooling, ensure that options are available to all. Some favor adopting a **single-payer system**. The delivery of care would operate much like Medicare, where private entities provide care and are paid directly by the federal government. Financing of single payer proposals differ but usually involve a

combination of a tax on employers and individuals. The other major approach is an **individual insurance system**, in which everyone buys their coverage on the individual market. Proposals typically combine a regulated individual market with tax credits and use competition among private plans to set benefits and lower costs. In both systems, every person would be required to participate.

**Effects on Coverage:** Proponents argue that a single-payer system would lower health care costs through its ability to negotiate prices, while those favoring the individual insurance system believe that the market would control costs. Because of their scope, each of these approaches presents challenges. They would require extensive changes in the insurance industry, employer-employee relationship and funding streams of coverage. Because they both disrupt existing payment systems and cover all people, the cost to the federal government would be high. Benefits would be set quite differently—the government determining them in a single-payer system, and private plans doing so in the individual market system. If insurers compete on attracting healthy people, they could discourage sick people from enrolling by limiting coverage of the types of benefits these people need.

**Effects on Women's Coverage:** Under either policy option, the degree to which the benefits and costs are expected to be shared by the individual would determine its effect on women. However, as discussed earlier, women tend to face greater challenges in the individual market. And Medicare's benefits need modification to ensure women's health care needs are met.

### *Building on FEHBP and Medicaid*

**Policy:** One comprehensive approach seeks to provide coverage to all Americans by building on ESI and the Medicaid program. All insurers who offer coverage through the FEHBP would be required to offer group coverage through a new national insurance pool. This pool would allow all individuals who lack ESI (including those who currently buy their insurance in the individual market) as well as all employers who want to provide ESI, to buy comprehensive coverage from this nationwide group. To ensure affordability, the proposal includes a refundable tax credit, which would be applicable to people in ESI plans as well as individuals obtaining individual insurance through the pool. The plan expands the Medicaid program as a safety net for all those below a certain income level. It abandons the current structure of the program that limits it to only certain categories of people (e.g. parents) and increases the federal contributions to the program so as to not overburden state budgets.

**Effects on Coverage:** This policy proposal would cover all Americans and provide subsidies to those who face financial barriers to care. This approach maintains the complexity of the nation's health care system by keeping in tact different types of insurance with different benefits and eligibility rules. This effect is both a strength and a weakness. Because it builds on the current system, it may be easier to implement than other proposals for universal coverage. However, many believe that the piecemeal nature of our system is what keeps it from providing quality and comprehensive health care to everyone.

**Effects on Women's Coverage:** Because of women's changing situations through their lifespan, particularly their movement in and out of the labor force and changing family status for dependent coverage, this policy could be designed to guarantee affordable and comprehensive benefits regardless of where women fall within the system. However, their access to benefits would vary depending on their health plan choice, age and other characteristics.

### *State Universal Health Coverage Initiatives*

**Policy:** An alternative to a national plan to insure all people is to encourage states to do so. With or without federal assistance, states could develop comprehensive approaches to coverage for all their residents. Hawaii had such a system in the past. Several states<sup>33</sup> are in the process of attempting this type of coverage. Massachusetts is currently leading the pack, as it passed a law in 2006 that requires all residents to have health insurance<sup>34</sup> and created several options for its residents to obtain insurance. The law includes subsidies to help low-income individuals with income

up to 300% of poverty buy insurance. The law also contains a requirement that most employers help pay for health insurance or face a penalty of \$295 a year per worker. The law anticipates that new insurance plans will be developed at an affordable rate for individuals who need to buy coverage on their own. Other states are considering similar approaches or variations of their own. Some propose federal funding and waivers of existing laws to facilitate action at the state level. Some policymakers predict that state plans will lead to models that eventually can be adopted at the national level.

**Effects on Coverage:** Unlike the federal government, states are pursuing ways to get all their residents insured. However, states will require a large infusion of new federal dollars to achieve such coverage.<sup>35</sup> Without new funds, it is likely that only those states with relatively small uninsured populations, like Massachusetts, could afford to launch their own universal coverage plans. Also, the overall impact on coverage will likely be small in states with large numbers of low-income people unless the necessary financial support for these individuals is available.

**Effects on Women's Coverage:** The effect of a state approach on women's coverage depends on the policy approach. Women are at greater risk of losing coverage if employers continue dropping dependent coverage and states continue to cut back on Medicaid benefits and eligibility due to cost. But the success of such state approaches to coverage for women, given their needs, is largely dependent on whether there are sufficient state and federal financial resources available to assure the comprehensiveness and affordability of plans.

## CONCLUSION

For women, policy initiatives could have far-reaching benefits if they addressed the challenges that women face in obtaining and affording coverage, as described in the companion issue brief entitled *Women and Health Coverage: The Affordability Gap*. The same issues of affordability and comprehensiveness of benefits must be addressed whether health care coverage reforms are incremental and build on the current health care system or create a new single universal health care system for all. Regardless of what form these expansion efforts take, the following questions must be asked to determine which policies would have the most positive far reaching effects for women.

Does the proposal:

- ✓ Assure that everyone has coverage?
- ✓ Extend coverage to the uninsured without eroding the coverage of the insured?
- ✓ Utilize large groups so that the risk to any one individual is minimized?
- ✓ If building on employer-sponsored coverage, ensure that all employees, including part-time employees and dependents, have access to coverage?
- ✓ Enable individuals who are outside the labor force to obtain coverage?
- ✓ Provide subsidies to ensure that low-income individuals can afford health coverage?
- ✓ Ensure that health plans provide comprehensive benefits, including services that women need?
- ✓ Ensure that the out-of-pocket costs (e.g. co-payments and deductibles) are affordable relative to the individual's income?

Because the impact of proposals on women varies dramatically, these questions can serve as a tool to determine which policies would be most beneficial for them. A policy such as expanding Medicaid to cover more low-income parents would provide women that qualify with coverage that is comprehensive and affordable, as the program's cost-sharing requirements are appropriately minimal given the low-income of this population. To reach an additional set of women, a policy that allows businesses and individuals to buy into an existing large pool of insured individuals, such the Federal Employees Health Benefits Program (FEHBP), could provide affordable coverage

because individuals would share the risk of their health costs with a large group of people, thereby keeping the cost of each person's premiums down. This plan could be designed to work more beneficially for women, given their lower incomes on average than men, by using sliding scale subsidies for premium costs and providing a range of benefits and cost-sharing plans. Furthermore, a universal single-payer system based on Medicare could be designed to ensure that all women have comprehensive and affordable coverage. Benefits would have to include the range of services that women need, like cancer screenings and maternity coverage, and cost-sharing requirements would have to be appropriate relative to women's incomes, in order to be most effective.

Conversely, answering the questions listed above would point out the weaknesses of other proposals under consideration. For example, offering tax credits to encourage women to buy into the individual market would not help very many women because such plans are expensive to purchase, even with the help of a tax credit, and usually have limited benefits and high cost-sharing requirements. Most women would incur large costs for their care, even if they were able to buy the coverage. Additionally, this type of approach could result in some women losing their employer-sponsored coverage because some employers would drop coverage for their employees if tax credits were made available to them.

Providing health coverage for everyone is an achievable goal. Policymakers should seize the opportunity presented by the public's need and demand for change to eliminate coverage gaps and provide comprehensive health coverage. With the number of uninsured and underinsured people growing annually, now is the time to implement policies that truly meet the needs of both women and men in this country.

## ENDNOTES

- 1 Unless otherwise noted, all data in this summary is from Elizabeth M. Patchias and Judy Waxman, The Commonwealth Fund, "Women and Health Coverage: The Affordability Gap," April 2007.
- 2 Lisa Clemans-Cope *et al.*, Kaiser Commission on Medicaid and the Uninsured, "Changes in Employees' Health Insurance Coverage, 2001-2005," October 2006.
- 3 Analysis of the March 2005 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund (5.4 million versus 4.9 million).
- 4 The exclusion of part-time workers is not an issue with proposals that are not employer based, as an individual's employment status is not related to whether he or she accesses health insurance.
- 5 Dawn M Gencarelli, *Health Insurance Coverage for Small Employers* (Washington: The George Washington University, National Health Policy Forum, April 2005) [hereinafter Gencarelli].
- 6 Currently, there are a small number of associations that offer health benefits to their members in a similar fashion. This option provides those who do not have employer-sponsored insurance access to group insurance through their membership in a labor union, professional association, club or other organization.
- 7 Some proposals require that all insurers who participate in FEHBP open up their plans to individuals, while others require the insurers to offer group coverage through a national insurance pool which would be open to anyone who lacks ESI.
- 8 This outcome, known as adverse selection, refers to the problem of attracting members who are sicker than the general population and who therefore have higher than average costs. Given that premiums are based on the average risk of the entire group, premiums for everyone will go up under such a scenario.
- 9 Employers either reimburse the state for coverage of its employees by Medicaid or they pay into an account which funds a specially created public health insurance program for the uninsured.
- 10 Such a requirement is a component of the recently passed Massachusetts law, which will be discussed in greater detail later.
- 11 This law is part of the Consolidated Omnibus Budget Reconciliation Act, known as COBRA (29 USCS 1161 *et seq*).
- 12 Jennifer N Edwards *et al.*, The Commonwealth Fund, "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care," August 2003.
- 13 One of the main reasons cited for not continuing coverage through COBRA is cost. *Ibid*.
- 14 Tax-exempt Health Savings Accounts (HSAs) were created by the Medicare Modernization Act of 2003 (Public Law 108-173 [H.R. 1] December 8, 2003). They must be paired with a health plan carrying a deductible of at least \$1,000 for an individual policy and \$2,000 for a family policy. Both individuals and employers may contribute to an HSA, with a different maximum annual contribution for individual coverage and for family coverage. Withdrawals from an HSA may be made at any time and are excluded from taxable income if they are used to pay for qualified medical expenses. Individuals may roll over funds from one HSA to another without penalty.
- 15 Alternatively, an employer can set up an account (called a Health Reimbursement Account) that functions like an HSA, but does not have the tax advantages of an HSA and is owned by the employer. Employers may favor such accounts because they are not portable and therefore a departing employee will not take the funds with her.
- 16 The use of HSAs in the individual market raises issues for women because of the limited and expensive coverage, specifically with benefits such as maternity care, that exists in that market.
- 17 Withdrawals from an HSA are not taxed if they are used to pay for qualified medical expenses; withdrawals for non-qualified expenses are subject to regular tax as well as a 10 percent penalty, which is waived if the HSA owner dies, becomes disabled or is eligible for Medicare.
- 18 A recent study found that those in high-deductible health plans were more likely to have high out-of-pocket payments and to avoid or delay care. Paul Fronstein and Sara Collins, The Commonwealth Fund, "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," December 2005.
- 19 Government Accountability Office, "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans," GAO-06-798, August 8, 2006.
- 20 The full credit would only be available to those individuals making \$15,000 or less a year and families making \$25,000 or less a year. The credit continues to phase down as income rises and phases completely out when income reaches \$30,000 for individuals and \$60,000 for a family of four.
- 21 Tax credits may have the unintended effect of causing younger and healthier workers to opt out of ESI, leaving the pool of workers in the employer plans a sicker and older group on average. This would drive up the cost-per-covered-worker that these firms face in providing ESI and would, in turn, raise costs for everyone in those plans.
- 22 Sara Collins *et al.*, *Health Insurance Tax Credits: Will They Work for Women?* (New York: The Commonwealth Fund, December 2002); FamiliesUSA, *A 10-Foot Rope for a 40-Foot Hole, Tax Credits for the Uninsured* (Washington: FamiliesUSA, September 2001).
- 23 This extra premium is known as a rider.
- 24 Rating restrictions fall into three broad categories: a) pure community rating allows premiums to vary only based on geography, family size and benefit

packages, b) modified community rating allows premiums to vary based on age and gender, c) rating bands allow varying premiums but limit the amount that is charged (e.g. a person in poor health can not be charged more than twice the premium of a healthy individual). Gencarelli, *supra* note 5.

- 25 Please see the Massachusetts example in Nancy C. Turnbull and Nancy M. Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market, Short Case Studies of Six States* (New York: The Commonwealth Fund, February 2005).
- 26 Insurance would have to meet minimum standards to qualify for the deduction.
- 27 Currently, employer-based coverage is not included in taxable income at all.
- 28 Low-income is defined as having an income of 200% of the federal poverty level or below.
- 29 In 2005, the median income eligibility level for working parents was only 65% of FPL. National Women's Law Center, "Poor Parents on Medicaid Targeted for Cuts," February 2006.
- 30 Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (Washington: Kaiser Commission on Medicaid and the Uninsured, July 2004).
- 31 SCHIP is the State Children's Health Insurance Program, which is a federal grant to the states that allows for the coverage of certain low-income children.
- 32 Cathy Schoen *et al.*, The Commonwealth Fund Taskforce on the Future of Health Insurance, "Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70," January 2000).
- 33 Vermont has also passed a comprehensive health reform law that seeks to cover all its residents. Other states that are considering such laws include Pennsylvania, California and New York.
- 34 Individuals that do not purchase coverage by 2008 will face a penalty.
- 35 See Judy Solomon, Center on Budget and Policy Priorities, "President's 'Affordable Choices' Initiative Provides Little Support for State Efforts to Expand Health Coverage," April 2007.

APPENDIX TABLE A: STATE POLICIES FOR EMPLOYER-SPONSORED INSURANCE

State	# of Adults (19-64) with ESI		% of Adults (19-64) with ESI		Policy that Requires Some Employers to Provide Insurance (see page 5)	COBRA Expansion (see page 5)
	Men	Women	Men	Women		
Alabama	869,290	916,900	65%	64%		
Alaska	114,130	119,260	58%	61%		
Arizona	923,100	984,160	57%	58%		
Arkansas	450,310	461,120	58%	57%		
California	6,097,030	6,211,100	57%	57%		✓
Colorado	912,180	926,990	64%	65%		
Connecticut	707,650	773,380	70%	71%		
Delaware	172,180	185,780	70%	71%		
District of Columbia	106,120	119,030	61%	62%		
Florida	2,812,580	3,037,660	57%	59%		
Georgia	1,679,780	1,837,220	65%	66%		✓
Hawaii	260,010	268,290	72%	72%	✓	
Idaho	251,260	264,170	62%	62%		
Illinois	2,587,200	2,616,750	68%	69%		✓
Indiana	1,281,020	1,288,650	69%	68%		
Iowa	624,420	625,780	71%	70%		
Kansas	552,720	548,570	69%	67%		
Kentucky	752,830	798,720	61%	63%		
Louisiana	757,060	771,370	61%	56%		
Maine	241,630	249,090	62%	62%		
Maryland	1,135,750	1,262,360	69%	72%		✓
Massachusetts	1,331,130	1,402,190	67%	70%	✓	
Michigan	2,101,280	2,126,380	71%	69%		
Minnesota	1,174,270	1,188,170	72%	74%		✓
Mississippi	480,670	526,130	58%	60%		
Missouri	1,115,910	1,159,380	67%	67%		✓
Montana	147,660	153,990	53%	54%		
Nebraska	344,830	346,020	67%	66%		
Nevada	475,280	453,200	66%	65%		
New Hampshire	305,140	314,420	77%	77%		✓
New Jersey	1,825,450	1,938,890	70%	72%		
New Mexico	286,370	299,930	52%	52%		
New York	3,506,890	3,780,360	62%	63%		
North Carolina	1,517,840	1,626,980	61%	62%		
North Dakota	125,030	125,200	65%	65%		
Ohio	2,404,000	2,532,460	72%	71%		
Oklahoma	571,000	622,470	59%	60%		
Oregon	688,050	691,840	62%	63%		✓
Pennsylvania	2,540,920	2,582,970	71%	69%		
Rhode Island	207,050	225,310	67%	67%		
South Carolina	725,470	784,370	61%	62%		
South Dakota	135,740	142,900	63%	64%		
Tennessee	1,060,980	1,072,950	59%	58%		
Texas	3,728,070	3,801,270	57%	56%		
Utah	464,320	474,310	67%	69%		
Vermont	119,070	126,000	63%	65%		
Virginia	1,505,530	1,577,950	68%	68%		
Washington	1,211,490	1,236,990	64%	64%		
West Virginia	313,300	332,700	58%	61%		
Wisconsin	1,161,860	1,166,880	69%	70%		
Wyoming	96,150	94,620	64%	62%		
<b>United States</b>	<b>54,636,380</b>	<b>57,273,600</b>	<b>63%</b>	<b>63%</b>	<b>2</b>	<b>8</b>

**KEY:**

**Policy that Requires Some Employers to Provide Insurance:** States receive a check if they have a policy that requires some employers to provide health insurance to their employees.

**COBRA Expansion:** States receive a check if they extend the amount of time some individuals are eligible to receive COBRA in the event of divorce.

**SOURCES:**

**# and % of adults with ESI:** Estimates based on 2004 and 2005 Current Population Survey data, available at <http://www.statehealthfacts.org>. In March 2007, the U.S. Census Bureau identified an error in the health coverage data produced by their Current Population Surveys from 1995-2005, which overstate the uninsured nationally by 0.6 percentage points. Data presented here reflect this error, although corrected data are expected after the publication date of this Issue Brief.

**Policy that Requires Some Employers to Provide Insurance:** Data collected by the National Women's Law Center, March 2006.

**COBRA Expansion:** Georgetown University Health Policy Institute, 2006.

APPENDIX TABLE B: STATE POLICIES FOR INDIVIDUAL PRIVATE INSURANCE

State	# of Adults (19-64) with Individual Coverage		% of Adults (19-64) with Individual Coverage		Guaranteed Issue (see page 7)	Rating Restrictions (see page 7)	% of Private Sector Establishments Offering Insurance	
	Men	Women	Men	Women			Fewer Than 50 Employees	More Than 50 Employees
Alabama	50,970	64,600	4%	4%			44.8%	97.4%
Alaska	8,930	8,670	5%	4%			34.8%	95.4%
Arizona	129,490	127,990	8%	8%			38.5%	91.9%
Arkansas	46,450	50,100	6%	6%			25.7%	92.9%
California	799,470	855,780	7%	8%	✓		43.8%	93.1%
Colorado	106,280	108,360	7%	8%			40.8%	92.8%
Connecticut	49,130	47,750	5%	4%	✓		54.6%	96.2%
Delaware	7,350	9,160	3%	3%			49.1%	95.4%
District of Columbia	11,300	12,060	6%	6%	✓		69.1%	99.2%
Florida	300,050	361,960	6%	7%			41.4%	97.3%
Georgia	125,510	142,750	5%	5%			36.9%	93.3%
Hawaii	14,340	15,280	4%	4%			81.5%	99.9%
Idaho	31,620	34,640	8%	8%	✓	✓	41.1%	96.3%
Illinois	217,080	218,700	6%	6%			40.2%	95.7%
Indiana	70,760	90,520	4%	5%			35.5%	95.5%
Iowa	67,550	72,920	8%	8%	✓	✓	37.3%	97.4%
Kansas	66,500	59,970	8%	7%			41.4%	97.3%
Kentucky	70,360	63,550	6%	5%		✓	44.0%	92.4%
Louisiana	60,250	90,100	5%	6%		✓	34.9%	94.8%
Maine	20,620	18,900	5%	5%	✓	✓	42.7%	96.6%
Maryland	71,610	81,050	4%	5%			47.3%	96.7%
Massachusetts	92,400	107,550	5%	5%	✓	✓	56.2%	95.1%
Michigan	117,280	174,780	4%	6%	✓		50.3%	91.4%
Minnesota	138,630	134,620	8%	8%	✓	✓	42.9%	98.0%
Mississippi	33,910	39,030	4%	4%			28.4%	95.8%
Missouri	99,900	105,100	6%	6%			41.2%	92.3%
Montana	28,810	28,440	10%	10%			36.3%	94.7%
Nebraska	57,000	48,810	11%	9%			31.5%	94.8%
Nevada	33,000	35,820	5%	5%		✓	44.8%	96.0%
New Hampshire	13,150	15,050	3%	4%		✓	60.1%	99.6%
New Jersey	84,930	98,890	3%	4%	✓	✓	51.6%	94.4%
New Mexico	27,910	35,450	5%	6%		✓	37.6%	92.4%
New York	208,960	279,730	4%	5%	✓	✓	50.5%	98.6%
North Carolina	127,110	162,760	5%	6%	✓		43.1%	95.0%
North Dakota	23,570	20,890	12%	11%		✓	34.9%	96.3%
Ohio	129,610	136,690	4%	4%	✓		44.0%	98.5%
Oklahoma	50,930	46,770	5%	5%			32.0%	94.3%
Oregon	71,310	76,050	6%	7%	✓	✓	47.2%	98.0%
Pennsylvania	197,440	213,490	6%	6%	✓		54.4%	94.7%
Rhode Island	11,980	18,020	4%	5%	✓		55.4%	100.0%
South Carolina	62,830	58,430	5%	5%			39.9%	95.2%
South Dakota	24,120	23,900	11%	11%		✓	34.8%	91.9%
Tennessee	127,400	131,160	7%	7%			33.9%	95.2%
Texas	285,790	351,950	4%	5%			31.4%	96.1%
Utah	66,560	51,980	10%	8%	✓	✓	33.9%	96.0%
Vermont	12,840	11,440	7%	6%	✓	✓	46.1%	98.9%
Virginia	101,960	154,190	5%	7%	✓		47.7%	95.4%
Washington	110,560	132,410	6%	7%	✓	✓	45.9%	97.9%
West Virginia	15,730	17,380	3%	3%	✓		35.4%	97.5%
Wisconsin	122,960	111,970	7%	7%			44.0%	94.3%
Wyoming	13,660	13,790	9%	9%			31.9%	92.5%
United States	4,875,880	5,403,380	6%	6%	21	18	43.2%	95.4%

**KEY:**

**Guaranteed Issue:** States receive a check if they require that insurers accept certain applicants for coverage regardless of health or risk status.

**Rating Restrictions:** States receive a check if they have policies that limit the extent to which insurers charge different premiums to different individuals.

**SOURCES:**

**# and % of adults with Individual Coverage:** Estimates based on 2004 and 2005 Current Population Survey data, available at <http://www.statehealthfacts.org>. In March 2007, the U.S. Census Bureau identified an error in the health coverage data produced by their Current Population Surveys from 1995-2005, which overstate the uninsured nationally by 0.6 percentage points. Data presented here reflect this error, although corrected data are expected after the publication of this Issue Brief.

**% of Private Sector Establishments Offering Insurance:** Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, "2003 Medical Expenditure Panel Survey—Insurance Component," Table IIA.2, available at <http://www.statehealthfacts.org>.

**Guaranteed Issue and Rating Restrictions:** Kevin Lucia & Karen Pollitz, Georgetown University Health Policy Institute, 2005, available at <http://www.statehealthfacts.org>.

APPENDIX TABLE C: STATE POLICIES FOR PUBLIC PROGRAMS

State	# of Adults (19-64) with Medicaid		% of Adults (19-64) with Medicaid		Medicaid Income Eligibility Level for Parents at or above 100% of FPL (see page 8)	Public Insurance for Adults without Children (see page 9)
	Men	Women	Men	Women		
Alabama	80,540	138,080	6%	10%		
Alaska	14,170	17,300	7%	9%		
Arizona	121,110	199,040	7%	12%	✓	✓
Arkansas	45,950	71,330	6%	9%		
California	835,770	1,194,320	8%	11%	✓	
Colorado	45,870	80,060	3%	6%		
Connecticut	57,080	113,340	6%	10%	✓	
Delaware	12,890	23,420	5%	9%	✓	✓
District of Columbia	15,560	32,990	9%	17%	✓	✓
Florida	230,860	357,830	5%	7%		
Georgia	131,200	193,330	5%	7%		
Hawaii	18,660	28,650	5%	8%	✓	
Idaho	15,750	30,240	4%	7%		
Illinois	160,450	275,420	4%	7%	✓	✓
Indiana	78,090	142,200	4%	7%		
Iowa	35,390	64,460	4%	7%		
Kansas	29,490	53,320	4%	7%		
Kentucky	98,670	132,140	8%	10%		
Louisiana	68,080	115,220	5%	8%		
Maine	51,260	74,530	13%	18%	✓	
Maryland	49,390	76,250	3%	4%		
Massachusetts	186,780	232,330	9%	12%	✓	✓
Michigan	177,030	307,550	6%	10%		
Minnesota	81,990	117,460	5%	7%	✓	
Mississippi	77,160	96,970	9%	11%		
Missouri	99,420	164,070	6%	10%		
Montana	15,910	22,840	6%	8%		
Nebraska	14,200	33,200	3%	6%		
Nevada	17,450	35,540	2%	5%		
New Hampshire	4,870	13,270	1%	3%		
New Jersey	113,290	146,550	4%	5%	✓	
New Mexico	39,300	63,110	7%	11%		
New York	533,480	874,350	9%	15%	✓	✓
North Carolina	115,430	228,880	5%	9%		
North Dakota	8,320	13,770	4%	7%		
Ohio	132,160	337,970	4%	9%		
Oklahoma	35,160	62,580	4%	6%		
Oregon	56,970	94,030	5%	9%	✓	
Pennsylvania	195,790	320,880	5%	9%		
Rhode Island	30,500	46,950	10%	14%	✓	
South Carolina	80,530	128,010	7%	10%		
South Dakota	9,540	16,550	4%	7%		
Tennessee	178,720	284,350	10%	15%		
Texas	276,270	442,850	4%	7%		
Utah	25,380	44,630	4%	6%		
Vermont	21,160	27,280	11%	14%	✓	✓
Virginia	57,240	100,770	3%	4%		
Washington	97,960	190,570	5%	10%		
West Virginia	45,320	53,250	8%	10%		
Wisconsin	79,770	157,140	5%	9%		
Wyoming	5,610	8,990	4%	6%		
United States	5,366,670	8,387,630	6%	9%	15	7

**KEY:**

**Medicaid Eligibility for Parents:** States receive a check if they provide coverage to parents at or above 100% of the federal poverty level.

**Public Insurance for Childless Adults:** States receive a check if they provide comprehensive coverage to childless, nondisabled, nonelderly adults up to a specific income level, without an enrollment gap.

**SOURCES:**

**# and % of adults with Medicaid:** Estimates based on 2004 and 2005 Current Population Survey data, available at <http://www.statehealthfacts.org>. In March 2007, the U.S. Census Bureau identified an error in the health coverage data produced by their Current Population Surveys from 1995-2005, which overstate the uninsured nationally by 0.6 percentage points. Data presented here reflect this error, although corrected data are expected after the publication date of this Issue Brief.

**Medicaid Eligibility for Parents and Public Insurance for Childless Adults:** Data collected by the National Women's Law Center, March 2006.



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The National Women's Law Center is a nonprofit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families, including employment, education, health and reproductive rights, and family economic security.

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## GLOSSARY OF HEALTH CARE TERMS \*

**Adjusted Community Rating** - A method of determining health care premiums where the premium is based on the average cost of health services used by all customers in a specific service area. When community rating is in place, insurance companies are required to charge the same premium to all their customers for the same type and amounts of coverage. It is a way of spreading the cost of medical insurance among all the policyholders of a particular insurance company plan. *Adjusted community rating* allows some variation in premiums but limits the extent of the variation (for example, within a band no higher than 25 percent of average or lower than 25 percent of average).

**Advanceable Tax Credit** - As it relates to expanding health coverage, a tax credit provided to cover the cost of purchasing health coverage in the individual market where the monthly payments can be sent directly to a health insurance provider, and the recipient need not wait to file a tax return and receive the subsidy as a tax credit or refund.

**Adverse Selection** - The trend wherein people purchase insurance only when they become sick and have significant expenses. If people do not purchase insurance until they are sick and need it, the individual insurance market may become a pool only for the sick, with no healthy members. This drives up premiums in the individual market. Adverse selection can also occur when healthier individuals are siphoned into certain plans (generally with fewer benefits and lower premiums) and sicker individuals into other plans (which offer more benefits).

**Beneficiary** - A person who receives benefits. The term is commonly applied to anyone receiving benefits under the Medicare or Medicaid programs or who is covered under a private health insurance plan.

**Benefit Cap** - A dollar limit placed on the amount of coverage that can be provided to an individual in a given time period, which is usually one year.

**Benefit Package** - A group of guaranteed services provided by a health plan to its members.

**Block Grant** - A lump sum of money given to a state or local governing agency based on a formula to be spent on services such as health care coverage.

Generally, the purposes of block grants are broadly defined, with few restrictions mandated by the funding source. Restrictions can be imposed by the re-granting agency.

**Carve-Out** - A health care delivery and financing arrangement in which certain specific health care services that are covered benefits (e.g. mental health services) are administered and funded separately from general health care services. The carve-out is typically done through separate contracting for services to a special population. As it relates to Medicaid, a set of services (such as behavioral health services) that are provided separately, or a specific population (such as people with HIV or children with special needs) that is not required to enroll in a Medicaid managed care program. These services or populations are said to be “carved out” and handled separately, either in fee-for-service plans or through a separate managed care organization.

**Case Management** - A means of coordinating care for people with multiple, often complex health care needs. As it relates to managed care, a system that requires that a single individual in the provider organization be responsible for arranging and approving all services needed. Ideally, case management should increase consumers' access to appropriate care through specialists and ensure that full information about a consumer's health conditions follow him or her through the health care system. In the context of private managed care, case management by a gatekeeper can be inappropriately motivated by the goal of reducing their health care costs. In the context of Medicaid, case management and managed care delivery systems must be examined carefully to determine if cost concerns are overriding the positive goal of coordinating care.

**Categorically Needy** - As it relates to Medicaid, a beneficiary is deemed categorically needy if she is eligible for coverage because she meets certain income requirements and falls into a specific population category: families with children; pregnant women; and people who are blind, disabled, or over 65. People who do not fall into these categories cannot qualify for Medicaid, no matter how low their incomes (unless their state has obtained a federal Section 1115 waiver to cover additional groups).

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\* The National Women's Law Center thanks Families USA for sharing this glossary of health care terms for inclusion in the *Reform Matters Toolkit*. This glossary is an excerpt of the full Families USA “Glossary of Health Care Terms” which can be found at: <http://www.familiesusa.org/resources/tools-for-advocates/kits/glossary-health-care.html>.

**Centers for Medicare and Medicaid Services (CMS)** - CMS is the name for the agency within the Department of Health and Human Services (HHS) that oversees Medicare and Medicaid. It was previously known as the Health Care Financing Administration (HCFA).

**CHIP** - see *State Children's Health Insurance Program (SCHIP)*

**COBRA** – See *Consolidated Omnibus Budget Reconciliation Act of 1985*.

**Co-Insurance** - The portion of covered health care expenses that must be paid, in addition to the deductible, by the health plan members. The figure is usually expressed in a ratio, such as 80/20, where the insurer pays 80 percent and the client pays the remaining 20 percent of the bill (*see Cost-Sharing*).

**Community Rating** - A method of determining health care premiums where the premium is based on the average cost of health services used by all customers in a specific service area. When community rating is in place, insurance companies are required to charge the same premium to all their customers for the same type and amounts of coverage. It is a way of spreading the cost of medical insurance among all the policyholders of a particular insurance company plan.

**Pure community rating** requires insurers to set the same premiums for everyone in a community. Plans cannot vary premiums at all based on health status, claims history, or age, but they may be allowed to vary premiums within a state based on geographical location and/or family composition.

**Adjusted community** rating likewise prohibits insurers from varying premiums in a community based on health status or claims history, but it does allow them to vary rates based on more factors than geography and family composition. For example, it may allow some variation in premiums but limit that variation within a band no higher than 25 percent of average or lower than 25 percent of average.

**Connector** – This term originated with the Massachusetts Health Reform of 2006. A health insurance “connector” (also known as an “exchange”) is a structure that facilitates enrollment of individuals, families, and small businesses in private health coverage. It creates a common marketplace where consumers can compare their health coverage options. It may also play a central role in outreach and education about newly available coverage and assist employers in establishing Section 125 pre-tax

health plans for employees.

**Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** - A provision of this federal law requires that certain employers permit laid-off workers and their dependants to remain in the employee health plan for a specified period of time. Employees must pay the full cost of the premium (including the share formerly paid by the employer).

**“Consumer Driven” Health Plans** – This term is used by different people to mean different things. One of the more common ways this term is used is to refer to a high-deductible plan that may be linked to a Health Savings Account (HSA – see below). The term is also used to refer to a defined contribution plan (see below) in which an employer offers an employee an account with a fixed dollar amount of money in it that is used to pay for health care coverage or services. Both of these kinds of plans—while purportedly giving consumers more “choice” and “control” over their health care—really shift the risk of incurring high health care costs and out-of-pocket costs from employers and insurance companies to employees.

**Continuous Eligibility** – A policy that states can apply to children's Medicaid and SCHIP coverage that allows an individual to remain eligible for the program for a full 12 months regardless of changes in family income. This policy reduces the paperwork burden on families and helps prevent children from losing coverage as family situations change.

**Copayment** - The amount a plan member has to pay each time he or she sees a doctor, fills a prescription, or receives other medical services. For example, most health plans require enrollees to pay a set dollar amount for each physician office visit or each prescription drug. (*see Cost-Sharing*)

**Cost-Sharing** - A provision of private or public health coverage that requires the beneficiary to pay a portion of the costs of covered services.

**Crowd-Out** – A term used to describe the substitution of public coverage for private coverage. The term has also been used to convey the idea that, when expanding access to subsidized coverage in order to cover the uninsured, the expansion will prompt some privately insured individuals to drop their existing coverage and take advantage of the public subsidy. This issue has been particularly contentious in the children's health debate, as some have argued that large numbers of families drop private coverage in favor of SCHIP or Medicaid. Studies have found varying degrees of crowd-out in these programs, but most reports have found it to be minimal.

**Cultural Competence** – The capacity of service providers to respect and respond to individual and cultural differences when caring for diverse

populations.

**Deductible** - A set dollar amount that must be paid *before insurance coverage begins*. For example, many private insurance policies require payment of several hundred dollars out-of-pocket before the insurance will pay for medical care. Medicare also requires the payment of a deductible each year. In 2006, the deductible for Medicare Part A (hospitalization) is \$952, and the deductible for Medicare Part B (physician and other outpatient non-pharmacy services) is \$124. For Medicare's new drug benefit, Medicare Part D, the standard deductible is \$250, but this varies by drug plan.

**Deficit Reduction Act (DRA)** - In February 2006, President Bush signed into law budget reconciliation legislation, known as the Deficit Reduction Act (DRA), that fundamentally alters many aspects of the Medicaid program. Some of these changes are mandatory provisions that states must enact and that will make it more difficult for people to either qualify for or enroll in Medicaid. Other changes are optional provisions that allow states to make unprecedented changes to the Medicaid program through state plan amendments.

**Disparities in Health** – Differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups.

**Disparities in Health Care** – Differences between two or more population groups in health care access, coverage, and quality of care *not due to different health needs*. This can include differences in preventive, diagnostic, and treatment services between population groups.

**Dual Eligible** - A low-income Medicare beneficiary who also receives full Medicaid benefits.

**Employee Retirement Income Security Act of 1974 (ERISA)** - A federal law governing employee benefit programs. As it relates to health insurance, ERISA includes general protections about benefits and about the disclosure of information to employees in the plan. ERISA also prevents states from regulating health insurance if the employer "self insures."

**ERISA** – See *Employment Retirement Income Security Act of 1974*.

**Federal Employees Health Benefits Program (FEHBP)** - The health benefits plan for employees of the federal government. The Office of Personnel Management (OPM), which administers FEHBP, approves a variety of health benefit plans from which employees may choose. All plans must offer similar core benefits, and plans can also offer additional benefits. The government pays no more than 75 percent of the cost of an employee's chosen plan,

and the employee pays the rest.

**Federal Match** – For the Medicaid and SCHIP programs, the federal government matches what states contribute to these programs. These match rates vary by state and program.

**Federal Poverty Level** - Guidelines established by the Department of Health and Human Services that are used to determine an individual's or family's eligibility for various federal and non-federal programs. Federal poverty levels vary by family size and, to a small extent, location (Alaska and Hawaii have higher rates than the 48 contiguous states and the District of Columbia).

**Fee-for-Service (or Indemnity) Insurance** - Health insurance plans that reimburse physicians and hospitals for each individual service they provide. These plans allow clients to choose any physician or hospital. Managed care is an alternative to fee-for-service medicine.

**FEHBP** – See *Federal Employees Health Benefits Program*.

**Freedom of Choice** - A Medicaid provision that requires states to allow beneficiaries the freedom to choose providers. States can seek Section 1915 and 1115 waivers of the freedom-of-choice requirement.

**Gatekeeper Physician** - A primary care physician who controls the access of his or her HMO patients to specialty medical care.

**Generic Drug** – A drug product that is no longer covered by patent protection and thus may be produced and/or distributed by many firms. Generic drugs are FDA reviewed and must be bio-equivalent, which means that they must have the same active ingredients and be absorbed by the body the same way as their brand-name counterparts. Generic drugs usually cost significantly less than their brand-name counterparts.

**Guaranteed Issue** – A requirement (usually a state law) that insurers sell a policy to anyone who seeks one, regardless of the applicant's health status, claims history, age, or the industry in which he or she is employed. This requirement also guarantees that the coverage will be renewed as long as the premium is paid.

**Guaranteed Renewal** – A requirement that insurers renew the policies of policyholders. Such requirements are established to prevent insurers from dropping policyholders who become ill and have high medical bills.

**Health Information Technology (HIT)** - The use of electronic technology, such as computerized medical records, to provide comprehensive management of medical information and its secure exchange

between health care consumers and providers, as well as to streamline health care delivery.

**Health Insurance Portability and Accountability Act (HIPAA)** – A federal law that sought to improve the “portability” of benefits by making it easier for workers to move from job to job without the risk of being locked out of insurance or having to wait for coverage of preexisting medical conditions. The bill also prohibits insurers from discriminating against workers based on their medical history (or that of their dependents).

**Health Maintenance Organization (HMO)** - A type of managed care health plan that provides health care to insured people through a network of providers within a defined geographic area. The providers may be employees or contractors of the HMO. The HMO providers are responsible for an individual group of patients, and they generally receive a fixed amount of money per month to cover the care of each patient (this is called “capitation”). One advantage of HMO plans has been that they often did not charge deductibles and they often had lower co-insurance or copayments. HMOs were designed to control costs by limiting access to specialty care. In theory, the HMO gatekeeper or primary care provider would help the consumer avoid unnecessary specialist care, but in practice, it is argued that needed specialty care is unduly restricted. Thus traditional HMOs fell out of favor in the mid-1990s.

**Health Savings Accounts (HSAs)** – Health Saving Accounts (HSAs) were established as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). HSAs offer tax benefits for people who purchase insurance policies with high deductibles. To qualify for the HSA tax break, the policy must have a deductible of at least \$1,000 (for an individual) or \$2,000 (for a family), but the deductibles may run as high as \$10,200. An HSA is a tax-preferred savings account. Deposits into the HSA may be deducted from income for federal income taxes. A maximum of \$2,600 (for an individual) or \$5,150 (for a family) can be deducted in one year. The tax-deductible contributions may be placed into an HSA by an individual, an employer, or both. Individuals can get a small tax advantage if they contribute to their HSAs, but the amount they save on federal taxes depends on their income, tax liability, and how much they (not their employers) contribute to their HSAs. For many people, an HSA will provide little or no tax break. Withdrawals from health savings accounts that are used to pay for out-of-pocket health care costs are tax free, while withdrawals for non-medical uses are subject to income tax and a 10 percent penalty for people under the age of 65. Money that is not used can be rolled over from one year to the next. Individuals over the age of 65 may withdraw money from their accounts—for any reason—without being taxed. Money in the accounts can be invested in stocks and bonds without incurring tax on the earnings.

**High-Risk Pool** – A nonprofit association created by states as an alternative for individuals who have been denied health insurance because of a preexisting condition or whose premiums are rated significantly higher than the average due to health status or claims experience. HIPAA (see above) allows states to use high-risk pools to satisfy the statutory requirements for ensuring access to health insurance coverage for certain individuals. By law, premiums are capped, and while they are somewhat higher than premiums charged to healthy people, they are not as high as premiums for unhealthy individuals. High-risk pools are subsidized in order to keep premiums within the state’s cap.

**HIPAA** - *see Health Insurance Portability and Accountability Act.*

**HSAs** – *See Health Savings Accounts.*

**Individual Mandate** – A law requiring all state residents to obtain health insurance. Currently, Massachusetts is the only state with an individual mandate.

**Limited English Proficiency (LEP)** – Individuals who do not speak English as their primary language and have a limited ability to read, write, speak, or understand English are described as having limited English proficiency. An LEP individual has a limited ability to communicate in English at a level that permits the person to interact effectively with health care providers or social service agencies. According to the 2005 American Community Survey, more than 23 million individuals (8.3 percent of the population) speak English less than “very well.”

**Managed Care Organization (MCO)** - A system of health service delivery and financing that coordinates the use of health services by its members, designates covered health services, provides a specific provider network, and directs the use of medical care services. The two most common types of managed care organizations are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

**Medicaid** - The federal health insurance program established in 1965 through Title XIX of the Social Security Act. Medicaid pays for health services for low-income Americans under age 65, including children, pregnant women, and people with disabilities, and for nursing home care for impoverished older adults over 65. It is financed through both federal and state funds. Each state implements its own Medicaid program, and the amount allocated to each Medicaid program varies.

**Medicaid Waiver** – *see Waivers*

**Medical Home** – A primary care practice where a patient routinely seeks medical care and where a patient’s health history is known. A medical home is a

place where health care should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

**Medical Loss Ratio** – The percentage of premium dollars that health insurance companies spend on medical care, as opposed to administrative costs or retaining for profit.

**Medicare** - The federal health insurance program established in 1965 through Title XVIII of the Social Security Act that covers Americans who are age 65 or over, who are disabled, or who have been diagnosed with end-stage renal disease.

**Medicare Advantage (MA)** - Private Medicare health plans, usually managed care plans or HMOs, that have sometimes provided extra benefits that “traditional” Medicare did not cover. Plans may charge additional premiums. This program was formerly known as Medicare+Choice or Medicare Part C.

**Medicare Part A** (*also known as Hospital Insurance*) - Medicare Part A covers inpatient hospital care, home health care, hospice care, and limited skilled nursing care. Eligibility is normally based on prior payment of payroll taxes. Beneficiaries must pay an initial deductible each time they are ill and a copayment for some services.

**Medicare Part B** (*also known as Supplementary Medical Insurance*) - Medicare Part B covers physician services, medical supplies, and other outpatient treatment such as laboratory tests and x-rays. Medicare beneficiaries must pay a monthly premium for Part B coverage.

**Medicare Part D** (*also known as the Medicare prescription drug benefit*) - Medicare Part D provides for an outpatient prescription drug benefit that began in January 2006. Beneficiaries can remain in traditional Medicare and enroll in a separate, freestanding, private prescription drug plan (PDP), or they can enroll in an integrated Medicare Advantage plan that includes prescription drug coverage.

**Medicare Payment Advisory Commission (MedPAC)** – An independent body established by Congress to advise it on issues affecting the Medicare program.

**Medicare Prescription Drug Benefit** - *see Medicare Part D.*

**Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)** - Commonly known as the Medicare Modernization Act (MMA), this law most notably created a prescription drug program for Medicare beneficiaries, known as Medicare Part D. In addition, it increased the part B deductible, expanded private Medicare Advantage plans, and added new preventive benefits for

beneficiaries.

**Medigap (or Medicare Supplemental) Policy** - A privately purchased insurance policy that supplements Medicare coverage. The policy must meet requirements set by federal statute and by the National Association of Insurance Commissioners.

**Modified Community Rating** – *see Adjusted Community Rating.*

**Out-of-Pocket Maximum** – The upper limit of how much individuals or families must pay out of pocket in deductibles and coinsurance for covered medical services during a benefit period.

**Pay-for-Performance (P4P)** - The idea that there should be a direct link, based on accepted measures, between what is paid for health services and the value of the services provided. Pay-for-performance uses payment methods and other incentives to encourage physicians and other health care personnel to provide higher quality and efficiency, rather than higher volume.

**Pay or Play** – Legislation designed to expand health coverage that requires employers (within certain parameters) to either “play” by contributing to their employees’ health coverage or “pay” an assessment to the state which the state, in turn, uses to fund health coverage.

**Preexisting Condition Exclusion** – A policy of excluding certain people from obtaining insurance or treatment due to a preexisting medical condition.

**Preferred Provider Organizations (PPOs)** – A type of managed care plan in which enrollees can choose plan-selected providers who discount their fees. By visiting a PPO provider, a beneficiary will pay less money out-of-pocket for medical services than he or she would by visiting a non-PPO provider.

**Premium** - The charge (not including any deductibles or copayments) enrollees must pay for coverage under a health plan. Premiums are typically paid on a monthly basis.

**Premium Assistance** – The use of federal funds usually designated for public health coverage programs—especially Medicaid and SCHIP—to purchase (or subsidize the purchase of) private insurance.

**Presumptive Eligibility** - A policy that states can use in their Medicaid or SCHIP programs for children or pregnant women. This policy allows states to provide these individuals with immediate but temporary enrollment in Medicaid or SCHIP if they appear to meet program eligibility standards.

**Prior Authorization** - A requirement that an enrollee’s physician or insurance plan (or Medicaid

program) give approval in advance before a particular drug or service will be covered.

**Purchasing Pool** – As it relates to health coverage, a group of people brought together to enhance their bargaining power as well as to pool risks across individuals—the sickest to the healthiest. All purchasing pool members pay the same premium for a given plan, regardless of their health status.

**Rate Bands** – The variation in insurance premiums that is allowed by state regulations, expressed as a ratio or as a percentage of the index rate or average rate. Rate bands are used to limit the variation in premiums among individuals.

**Rate Regulation** – The process of overseeing and regulating the premiums—or rates—that insurance companies charge to their customers. States and the federal government regulate different kinds of insurance.

**Reinsurance** – Reinsurance is insurance for insurance companies. Its basic structure involves a primary insurance company that transfers, or cedes, the risk of high-cost claims to another private carrier or to a government-sponsored program. The insurer or government-sponsored program then assumes this risk and pays for some or all of these high-cost claims. There are two major types of government-sponsored reinsurance programs: 1) the government pays for some or all of the claims through general revenues; or 2) state law establishes an association of insurance companies that may want to cede risk and requires these companies to pool their resources to pay high-cost claims.

**Risk Pooling** – Under this process, risk for all individuals—including the healthy and the sick—is combined into one risk pool or group, and the group's total expected claims are evaluated. This is used to try to calculate the required funding (raised through premiums and/or other subsidies) to support the payment of all expected claims for all members of the risk pool.

**SCHIP** – See *State Children's Health Insurance*.

**Section 125 Cafeteria Plans** – Plans that allow employees to set aside pre-tax dollars for a variety of benefits, including flexible spending accounts (FSAs) and health insurance. These plans are named after Section 125 of the Internal Revenue Service code. Some states encourage or require certain businesses to establish cafeteria plans so that their workers will be able to pay for their share of health premiums with pre-tax dollars.

**Self-Insured Health Plan** – A health plan in which the employer assumes the financial risk of covering its employees, paying medical claims from its own resources.

**State Children's Health Insurance Program (SCHIP)** - The BBA of 1997 established Title XXI of the Social Security Act, which created the federal block grant program known as SCHIP. SCHIP provides funds to states to establish a health insurance program for targeted low-income children in families with incomes below 200 percent of the federal poverty level. States can: (1) expand Medicaid to cover children in families with higher incomes, (2) create a new health insurance program for children, or (3) do both. The program is financed with federal and state funds, with the federal government paying a greater share than it pays for the state's regular Medicaid program. Each state has a different SCHIP program.

**State Plan Amendment** - A Medicaid state plan is the document that defines how each state operates its Medicaid program. Making any major change to a state's Medicaid program usually requires an amendment to the Medicaid state plan. Amendments to the state plan must be filed and approved by the Centers for Medicare and Medicaid Services (CMS) before changes can be implemented.

**Tax Credits** – A dollar-for-dollar reduction in the amount of taxes an individual owes. Some tax credits are "refundable," meaning that if an individual owes less in taxes than the amount of the credit, he or she receives a refund and benefits from the full amount of the credit. The Earned Income Tax Credit is an example of a well-known federal program that works in such a manner.

**Trade Adjustment Assistance Reform Act of 2002 (TAARA) Health Insurance Subsidy** - The TAARA is geared toward helping retirees, their families, and other workers who have lost their employer-sponsored health coverage as a consequence of trade practices or bankruptcies. This legislation provides a subsidy, via the tax system, that covers 65 percent of the cost of purchasing health insurance from certain specified sources.

**Underinsured** – People whose insurance does not cover their necessary health care services, leaving them with out-of-pocket expenses that exceed their ability to pay.

**Waivers** - Sections 1115 and 1915 of the Social Security Act define specific circumstances under which the federal government may, at a state's request, "waive" certain provisions of the federal Medicaid laws. The "waiver" is the agreement between the federal government and the state that exempts the state from these provisions, and it includes special terms and conditions that define to whom and when these exemptions apply. For example, some states use Medicaid waivers to extend Medicaid coverage to childless adults who are not blind or disabled, a group that does not ordinarily qualify for Medicaid under federal laws.

**Home- and Community-Based Care** (*also known as 1915 (c) or 1915 (d)*) - A home- or community-based care waiver allows states to offer community-based long-term care services to Medicaid beneficiaries who would otherwise require nursing home care or other types of institutionalized care. Under this type of waiver, states provide a broad range of home- and community-based services to people who are older than 65, developmentally disabled, or chronically ill. States must apply to the Department of Health and Human Services (HHS) for each specific program.

**Section 1115** - Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services (HHS) to waive certain Medicaid requirements in order to allow states to establish demonstration projects that are “likely to further the goals of the Medicaid program.” One major goal of Medicaid is to provide health care to people with low incomes. States submit a waiver application to HHS, which must approve the application before the waiver can take effect. Recent Section 1115 waiver proposals have largely sought to reduce the health care services available in Medicaid and to eliminate certain rights that people in Medicaid have to get care.

**Section 1915 (b)** - A Section 1915(b) waiver allows states to waive Medicaid rules regarding the freedom to choose a provider, the establishment of statewide programs, and the comparability of Medicaid benefits to different

covered groups. Thus, states can require all or some categories of Medicaid beneficiaries to enroll in managed care, either throughout the state or in limited geographical areas. Since passage of the Balanced Budget Act of 1997, states can mandate managed care enrollment for many Medicaid beneficiaries without a Section 1915(b) waiver. A state must still, however, obtain such a waiver to mandate managed care enrollment for children with special needs, dual eligibles (people who are eligible for both Medicaid and Medicare), and Native Americans.

**Health Insurance Flexibility and Accountability (HIFA) Waiver** – This type of waiver is based on policy guidance issued by the Bush Administration in August 2001 that provides for fast-track approval of Section 1115 Medicaid and SCHIP waivers. HIFA gives states new flexibility to cut benefits and increase cost-sharing for some current beneficiaries. HIFA also requires states to include a private insurance component to their programs that would provide a subsidy to individuals for the purchase of available employer-sponsored or other private insurance instead of enrolling in the state's Medicaid or SCHIP program.

**Wraparound Benefits** – Benefits that Medicaid provides when it acts as a secondary insurer to Medicaid-eligible individuals who are enrolled in private plans (such as employer-based coverage) that do not cover all of the services that Medicaid covers.