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Issue Brief

Women and Health Coverage: The Affordability Gap

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ABSTRACT: Although men and women have some similar challenges with regard to health insurance, women face unique barriers to becoming insured. More significantly, women have greater difficulty affording health care services even once they are insured. On average, women have lower incomes than men and therefore have greater difficulty paying premiums. Women also are less likely than men to have coverage through their own employer and more likely to obtain coverage through their spouses; are more likely than men to have higher out-of-pocket health care expenses; and use more health care services than men and consequently are in greater need of comprehensive coverage. Proposals for improving health policy need to address these disparities.

* * * * *

Introduction

While lack of insurance is a major barrier to health care, having just any insurance does not guarantee access to affordable and comprehensive health care. In addition to the 44.8 million Americans without health coverage, there are an estimated 16 million more adults who, because of high out-of-pocket costs relative to their income, can be considered "underinsured."[1] Although men and women are at similar risk of not having health insurance, women—whether insured or uninsured—are more likely to report cost-related access problems. These problems can be attributed directly to women's lower average incomes compared with men and to their greater need for, and use of, health care services.

This issue brief examines the unique difficulties women encounter in obtaining and paying for health care. The data cited come primarily

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from three surveys: the Annual Social and Economic Supplement to the Current Population Survey (CPS), 2005; the Medical Expenditure Panel Survey (MEPS), 2004; and the Commonwealth Fund Biennial Health Insurance Survey, 2005 (see Study Methods box on page 10). In a companion report available from the National Women's Law Center, *Women and Health Coverage: A Framework for Moving Forward,*[2] the authors analyze various policy approaches to determine those that will best serve women's needs.

Insurance Coverage Patterns

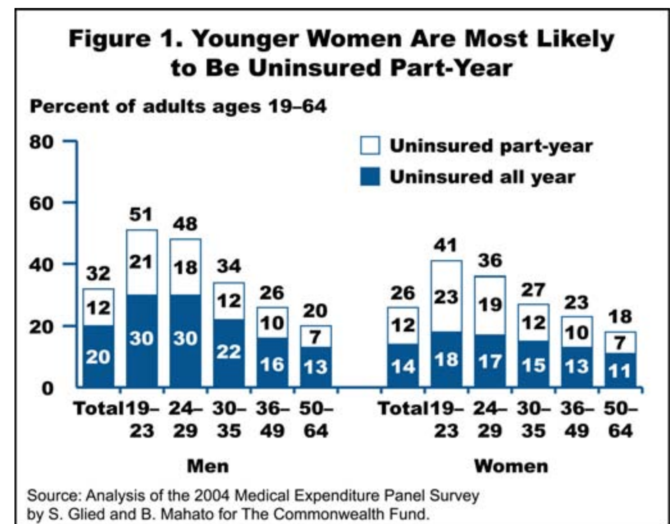
Currently, health insurance coverage patterns are similar for adult men and women (ages 19–64) in a number of ways, though important differences do exist. About two-thirds of nonelderly adults, or some 113 million people, are covered by employer-sponsored insurance. Another 10.3 million people (among whom women slightly outnumber men) purchase their health coverage through the individual insurance market; and 8.3 million men and women are insured through Medicare, military health coverage, or other sources. Medicaid insures nearly twice as many women as it does men (6.1 million vs. 3.5 million).[3]

Although health insurance coverage is vital for timely and meaningful access to health care, 44.8 million Americans, including children, currently lack such coverage. Uninsured men and women are more likely to be younger, be single, have a low-income, work in small businesses, and belong to a racial or ethnic minority than those who are insured (Table 1, p. 8).

In order to investigate the extent to which insured and uninsured women are accessing needed health care, it is important to tease out their patterns of health coverage.

Almost as many women are uninsured all year as are uninsured for part of the year.

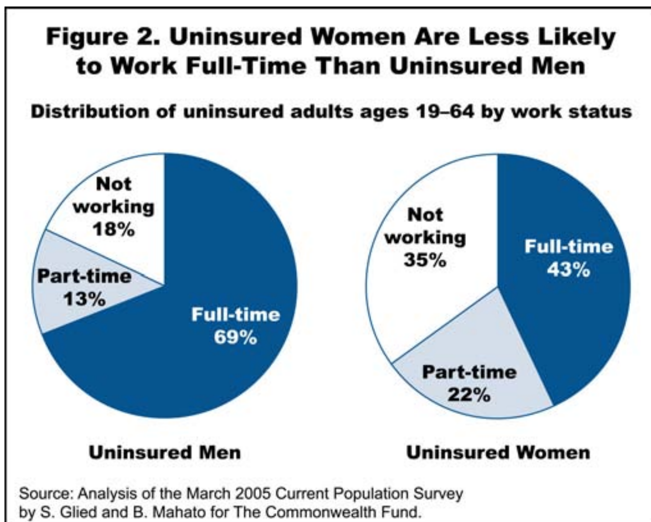
While 44.8 million people have no insurance for a whole year, many millions more people are uninsured for months at a time. When examined over a two-year period, the data reveal that a total of about 80 million people are uninsured for all or part of that time.[4] For women, being uninsured part of the year is almost as common as being uninsured all year: 12 percent of women are uninsured for part of the year, while 14 percent of women are uninsured all year (Figure 1). Younger women and men are the most likely to be uninsured for part of the year.



Women have less access to employer-sponsored insurance because they are less likely to be employed and more likely to work part-time.

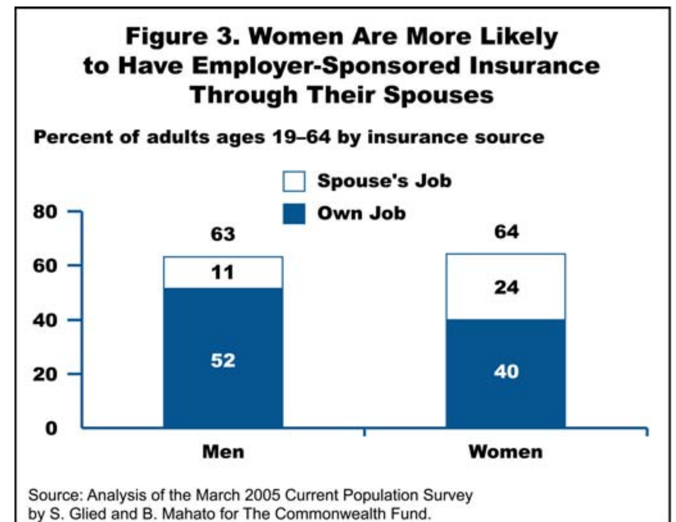
Individuals who are not employed or who work part-time are more likely to be uninsured; the uninsurance rate for those who are not working is 26 percent, while it is 18 percent for full-time workers (Table 1, p. 8). The employment status of uninsured women differs from that of men. Thirty-five percent of uninsured women do not work, compared with only 18 percent of uninsured men (Figure 2). When uninsured women do

work, they are more likely to work part-time than are uninsured men. While all part-time workers are less likely to be insured, only 13 percent of uninsured men work part-time while 22 percent of uninsured women work part-time.



Women are more likely to depend on their spouses for insurance and therefore face more instability in their coverage.

Women are more than twice as likely as men to get employer-sponsored insurance through their spouses. Twenty-four percent of women are insured through their spouse's job, compared with only 11 percent of men (Figure 3). Though it is beneficial that women have the option to get coverage through their spouses, such insurance (known as dependent coverage) is a less stable form of coverage. A dependent must rely not only on her spouse staying in the job but also on the continuation of the marriage and the employer's willingness to cover dependents. Recently, in an effort to contain their health care costs, employers have actually



been cutting back on dependent coverage. In fact, between 2001 and 2005, employers dropping such coverage accounted for 11 percent of the decline in employer-sponsored insurance overall.[5]

Older adults are particularly at risk. Among adults ages 50 to 64, there are 3.5 million uninsured women and 3.1 million uninsured men (Table 1, p. 8). Women are more likely to be married to an older spouse, which places them at risk of losing dependent coverage when their spouse becomes eligible for Medicare.[6] Women without coverage through their own employers who lose their spouse's coverage may be forced to turn to the individual market for their insurance, which is especially costly for those with health issues—not uncommon among women in the 50-to-64 age group.[7]

A small percentage of women purchase individual health insurance, which is more expensive to secure.

Only about 10.3 million adults, or 6 percent of nonelderly adults (ages 19–64), get insurance through the individual market.[8] According to one survey, roughly 58 million adults over a three-year period considered buying coverage in the individual market, yet close to 90 percent of them never purchased a plan.[9]

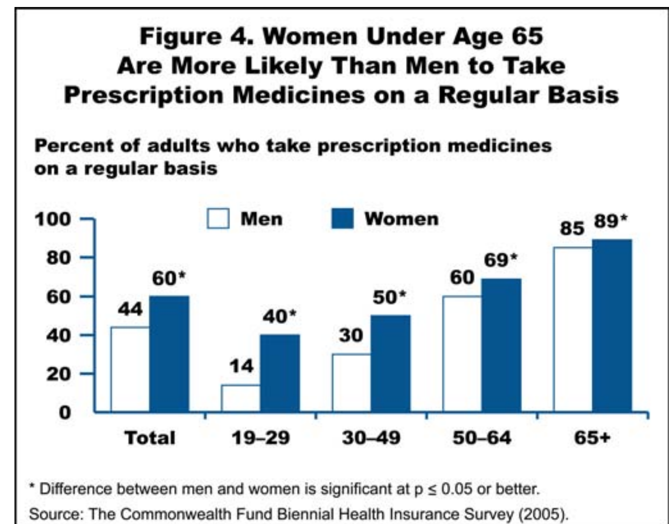
Slightly more women than men (5.4 million vs. 4.9 million) purchase insurance in the individual market.[10] Women with individual coverage have higher incomes (76% of women purchasing individual coverage are at 200 percent of the federal poverty level or higher), and are older (55% are ages 45–65).[11] More than one-third (35%) are unemployed.[12]

Women covered by individual health insurance are also relatively healthy: 88 percent report excellent, very good, or good health, while only 12 percent report they are in fair or poor health.[13] These findings suggest that women who have a greater need for health insurance face barriers in purchasing individual insurance coverage because they can be denied coverage altogether—for example, because of a preexisting condition—or charged unaffordably high rates.

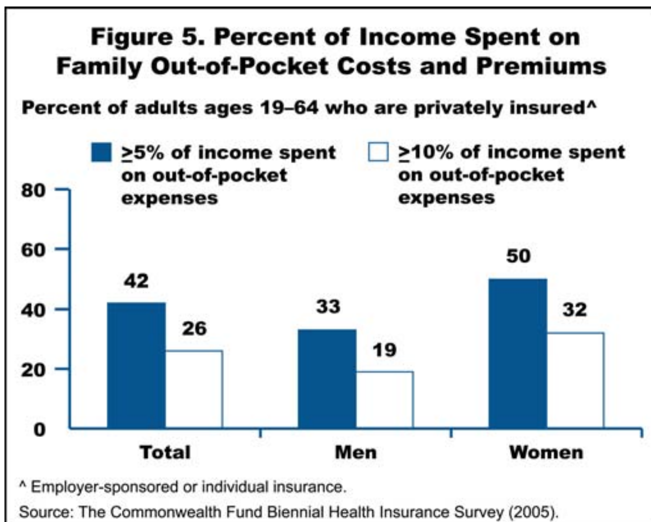
Women Face Difficulty in Affording Health Services

Women are more likely to have lower incomes than men. Women are somewhat more likely to be poor. Seventeen percent of women ages 19 to 64 are below 100 percent of the federal poverty level, compared with 13 percent of men in that age group; poverty rates for younger women are even greater.[14] In terms of earnings, in 2004 the median earnings of female workers age 15 and over were $22,224, compared with $32,486 for men. Among full-time workers, women earn only 76.5 cents for every dollar that men earn.[15]

On average, women use more health care services. Women are more likely than men to need health care throughout their lifetimes. Women's reproductive health needs require them to get regular check-ups, whether or not they have children, and women of all ages are more likely than men—60 percent versus 44 percent—to take prescription medications on a regular basis (Figure 4). For younger women, this difference is even greater; women ages 19 to 29 use prescription drugs at almost three times the rate of men in that age group. Further, women are more likely than men to have a chronic condition requiring ongoing treatment (38% vs. 30%).[16] Finally, certain mental health problems, including anxiety and depression, affect twice as many women as men.[17]



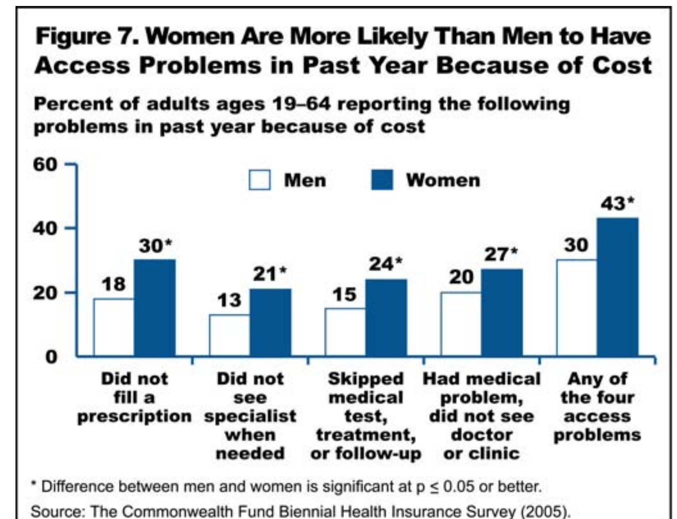
Women have higher out-of-pocket costs than men as a share of their income. About 12 percent of all insured individuals ages 19 to 64 are considered underinsured because they have high out-of-pocket costs relative to their income.[18] Because women's greater health care needs and rates of use, combined with their lower incomes, lead them to have higher out-of-pocket costs, more women than men are underinsured (16% vs. 9%). Women insured through employer-sponsored insurance or with an individual policy are more likely than men to spend more than 10 percent of their income on out-of-pocket costs and premiums (Figure 5).

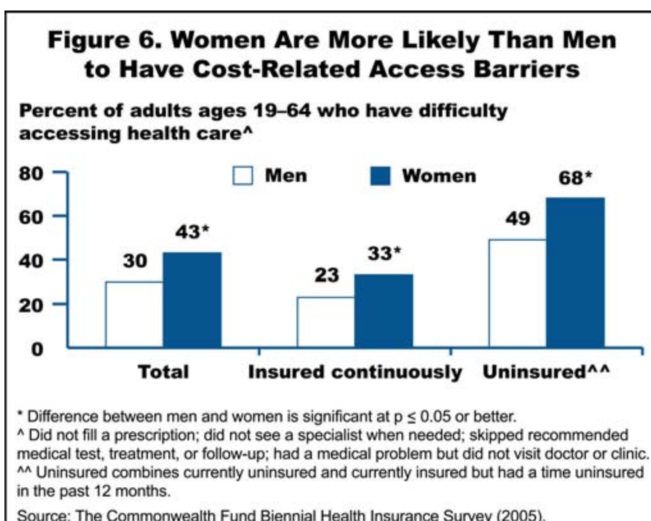


higher rates with every problem as compared with men (Figure 7). Though women are more likely to face cost-related access barriers regardless of their age, the barriers are particularly dramatic for young women (ages 19–29) when compared with young men—50 percent versus 33 percent (data not shown). Ironically, even though young adult women are more likely to have insurance than young adult men, half of these women reported problems accessing health care because of cost in the past year.

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%) (Figure 6). When asked which, if any, of four access problems were encountered in the past year, women reported

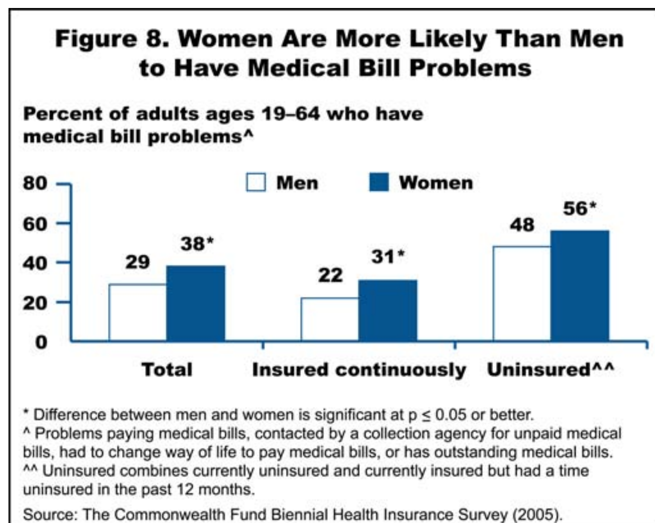


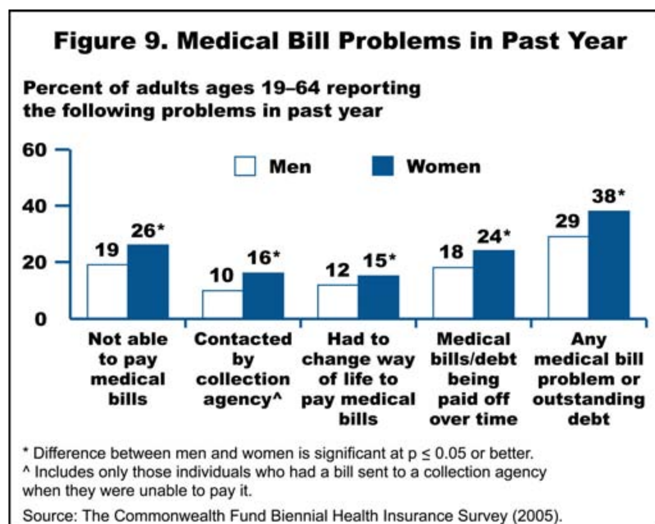


Women are more likely to have medical bill and debt problems.

Whether they are insured or uninsured, women are also somewhat more likely than men to have problems paying for their care.Nearly two of five women (38%) report medical bill problems, compared with 29 percent of men (Figure 8).[19] Among the uninsured, 56 percent of women report difficulty paying bills. About one-quarter (26%) of women said they were not able to pay

their medical bills (Figure 9). Adult women under age 50 have the greatest difficulty paying for care, possibly reflecting their responsibility both for their own medical care and that of their children (data not shown).





Conclusion

Though the data suggest that men and women have some similar challenges with regard to health insurance, women face unique barriers to becoming insured. In particular, women are less likely to have coverage through their own employer and more likely to obtain coverage through their spouses as dependents. More significantly, women have greater difficulty affording health care services even once they are insured. Women are more likely to have lower incomes than men and therefore have greater difficulty paying premiums. They are more likely to use more health care and to have higher out-of-pocket health care expenses. The combination of lower incomes and higher out-of-pocket spending means that many women are more likely to spend greater than 10 percent of their income on health care expenditures and premiums. Given these factors, policy proposals that provide comprehensive benefits at affordable cost would help more women obtain meaningful coverage. Conversely, reforms that result in higher out-of-pocket expenses and limited benefits will not significantly improve the health and financial security of women.[20]

Notes

[1] C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005):w5-289–w5-302.

[2] E. M. Patchias and J. G. Waxman, *Women and Health Coverage: A Framework for Moving Forward* (Washington, D.C.: National Women's Law Center, Apr. 2007).

[3] Analysis of the March 2005 Current Population Survey, by S. Glied and B. Mahato, for The Commonwealth Fund.

[4] ERIU Research Highlight, Economic Research Initiative, available at http://www.umich.edu/~eriu/qa-fastfacts.html.

[5] Ibid.

[6] J. M. Lambrew, *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (New York: The Commonwealth Fund, Aug. 2001).

[7] S. R. Collins, C. Schoen, M. M. Doty, A. L. Holmgren, and S. K. H. How, *Paying More for Less: Older Adults in the Individual Insurance Market* (New York: The Commonwealth Fund, June 2005).

[8] Analysis of the March 2005 Current Population Survey, by S. Glied and B. Mahato, for The Commonwealth Fund.

[9] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

[10] Analysis of the March 2005 Current Population Survey, by S. Glied and B. Mahato, for The Commonwealth Fund.

[11] A. Salganicoff, U. R. Rangi, and R. Wyn, *Women and Health Care: A National Profile* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, July 2005).

[12] Ibid.

[13] Salganicoff et al., *Women and Health Care,* 2005.

[14] NWLC calculations from the Current Population Survey 2005 Annual Social and Economic Supplement, Table POV34.

[15] Current Population Survey 2004 Poverty Tables, http://pubdb3.census.gov/macro/032005/pov/toc.htm.

[16] Salganicoff et al., *Women and Health Care,* 2005.

[17] National Women's Law Center and Oregon Health and Science University, *Making the Grade on Women's Health: A National and State-by-State Report Card* (Washington, D.C.: NWLC, 2004).

[18] Specifically, "underinsured" is defined either as having medical expenses (excluding premiums) that represent 10 percent or more of income; medical expenses (excluding premiums) for low income (defined as being below 200 percent of the federal poverty level) that represent 5 percent or more of income; or a deductible that represents 5 percent or more of income. Schoen et al., "Insured But Not Protected," 2005.

[20] Medical-bill problems include difficulty paying medical bills, has been contacted by a collection agency for unpaid medical bills, has had to change his or her way of life to pay medical bills, or has outstanding medical bills.

[19] Patchias and Waxman, *Women and Health Coverage,* 2007.

Table 1. Comparison of Men and Women Ages 19–64, 2004

	Total				Men				Women			
	Total distribution (%)	Number uninsured (millions)	Uninsured rate (%)	Distribution of uninsured (%)	Total distribution (%)	Number uninsured (millions)	Uninsured rate (%)	Distribution of uninsured (%)	Total distribution (%)	Number uninsured (millions)	Uninsured rate (%)	Distribution of uninsured (%)
Total in millions	178.1	36.5	36.5	36.5	87.8	19.7	19.7	19.7	90.3	16.7	16.7	16.7
Percent distribution	100%		20%	100%	100%		23%	100%	100%		19%	100%
Income (as a percent of poverty)												
<100%	15%	12.2	46%	33%	13%	6.0	53%	30%	17%	6.2	40%	37%
100%–199%	16%	10.0	35%	28%	16%	5.5	40%	28%	17%	4.6	30%	27%
200%+	69%	14.3	12%	39%	72%	8.3	13%	42%	66%	6.0	10%	36%
Race/Ethnicity												
White	68%	18.3	15%	50%	68%	9.8	16%	50%	68%	8.5	14%	51%
Black	12%	5.3	25%	15%	11%	2.7	28%	13%	13%	2.7	23%	16%
Hispanic	14%	10.3	42%	28%	15%	5.9	46%	30%	13%	4.4	37%	26%
Other	7%	2.6	22%	7%	6%	1.4	24%	7%	7%	1.2	20%	7%
Age												
19–23	11%	6.5	33%	18%	11%	3.6	36%	18%	11%	2.8	29%	17%
24–29	13%	7.2	30%	20%	14%	4.2	35%	21%	13%	3.0	26%	18%
30–35	14%	5.5	23%	15%	14%	3.1	26%	16%	13%	2.4	20%	14%
36–49	34%	10.7	18%	29%	34%	5.7	19%	29%	34%	5.0	16%	30%
50–64	28%	6.6	13%	18%	27%	3.1	13%	16%	28%	3.5	14%	21%
Family status												
Married with children	31%	7.5	14%	21%	30%	3.6	14%	18%	32%	3.8	13%	23%
Married w/o children	27%	7.2	15%	20%	27%	3.5	15%	18%	26%	3.6	15%	22%
Single with children	7%	3.1	24%	8%	4%	1.0	28%	5%	10%	2.1	23%	12%
Single w/o children	35%	18.7	30%	51%	39%	11.5	34%	58%	32%	7.2	25%	43%

Table 1. Comparison of Men and Women Ages 19–64, 2004 (continued)

	Total				Men				Women			
	Total distri-bution (%)	Number unin-sured (millions)	Unin-sured rate (%)	Distri-bution of uninsured (%)	Total distri-bution (%)	Number unin-sured (millions)	Unin-sured rate (%)	Distri-bution of uninsured (%)	Total distri-bution (%)	Number unin-sured (millions)	Unin-sured rate (%)	Distri-bution of uninsured (%)
Total in millions	178.1	36.5	36.5	36.5	87.8	19.7	19.7	19.7	90.3	16.7	16.7	16.7
Percent distribution	100%		20%	100%	100%		23%	100%	100%		19%	100%
Work status												
Full-time	66%	20.9	18%	57%	78%	13.7	20%	69%	55%	7.2	14%	43%
Part-time	13%	6.1	26%	17%	8%	2.5	35%	13%	18%	3.6	22%	22%
Not working	20%	9.5	26%	26%	14%	3.6	29%	18%	26%	5.9	25%	35%
Firm size												
<25	24%	13.4	31%	37%	28%	8.7	35%	44%	20%	4.7	26%	28%
25–99	10%	3.5	20%	10%	11%	2.2	22%	11%	9%	1.4	17%	8%
100–499	10%	2.8	15%	8%	11%	1.6	17%	8%	10%	1.1	13%	7%
500+	35%	7.3	12%	20%	35%	3.6	12%	18%	35%	3.7	12%	22%
Not working	20%	9.5	26%	26%	14%	3.6	29%	18%	26%	5.9	25%	35%
Health status												
Excellent	30%	9.4	17%	26%	31%	5.3	19%	27%	30%	4.1	15%	25%
Very good	34%	12.0	20%	33%	34%	6.6	22%	33%	34%	5.4	18%	32%
Good	25%	11.1	25%	30%	24%	5.9	27%	30%	25%	5.2	23%	31%
Fair	8%	3.1	23%	8%	7%	1.6	25%	8%	8%	1.5	21%	9%
Poor	3%	0.9	16%	2%	3%	0.4	17%	2%	3%	0.5	16%	3%

Note: Subgroup numbers and percents may not sum to totals because of rounding.

Source: Analysis of the March 2005 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund.

Study Methods

Most data in this issue brief are from three surveys: the Annual Social and Economic Supplement to the Current Population Survey (CPS), 2005; the Medical Expenditure Panel Survey (MEPS), 2004; and the Commonwealth Fund Biennial Health Insurance Survey, 2005. Sherry Glied and Bisundev Mahato of Columbia University's Mailman School of Public Health provided analysis of the CPS and MEPS.

The CPS and MEPS are federal surveys sponsored by the Census Bureau and the Agency for Healthcare Research and Quality, respectively. The CPS, which is the primary source of information on U.S. labor-force characteristics, is conducted monthly on a sample of some 57,000 households representing approximately 140,000 people. The Annual Social and Economic Supplement to the CPS is conducted in March of each year with a sample of about 99,000 households. The MEPS uses an overlapping-panel design in which data are collected in a series of five interviews over a 30-month period, with a new panel started each year. The sample size in 2004 was about 13,000 families, representing approximately 33,000 people.

The 2005 Commonwealth Fund Biennial Health Insurance Survey was conducted by Princeton Survey Research Associates International from August 18, 2005, through January 5, 2006. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 4,350 adults age 19 and older living in the continental United States. Statistical results are weighted to correct for the disproportionate sample design and to make the final total sample results representative of all adults age 19 and older living in the continental U.S. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, and telephone service interruption, using the U.S. Census Bureau's 2005 Annual Social and Economic Supplement. The resulting weighted sample is representative of the nation's approximately 212 million adults age 19 and older.

About the Authors

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Judy Waxman is vice president of health and reproductive rights at the National Women's Law Center. Prior to joining the Center, Ms. Waxman served as deputy executive director at Families USA for over a decade. She previously was as a professional staff member with the Pepper Commission. Ms. Waxman has also been a managing attorney of the East Coast Office of the National Health Law Program, an adjunct professor at the Georgetown University Law Center, and an attorney for the U.S. Department of Health and Human Services. She also has served as president of the board of directors of the Women's Medical Center, a nonprofit health clinic. She holds a law degree from American University and a bachelor's degree from the University of Miami, in Florida.

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The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

Women, Tax Policy, and Health Reform

Our national tax system already plays a major role in the way Americans get their health insurance, and some health reform plans propose to modify the federal tax code in ways that would change employers' incentives to offer—and individuals' incentives to purchase—health coverage. These proposals, which would rely on the tax code as a tool to expand private health insurance to more individuals, have unique implications for women.

What Role Does the Tax System Currently Play in the Way Women Get Health Coverage?

The tax treatment of health insurance depends on where you get it; tax treatment varies by whether coverage is provided by an employer or purchased in the individual insurance market, and whether or not it is purchased by a self-employed individual.

- **Employer-sponsored health insurance** (ESI) is treated as a nontaxable fringe benefit, so it is not counted as part of the total compensation that is subject to income tax for employees, nor is it subject to the payroll tax that employers pay.[1] Employers get an additional tax benefit because they can deduct 100 percent of their spending on employee health premiums as an ordinary business expense. In part because of this favorable tax treatment, most nonelderly Americans get their health insurance at work. In 2007, nearly two-thirds of adult women were covered through ESI, either in their own name or as a spouse or dependent.[2]

- **Insurance purchased in the individual market** (or directly from an insurance company), in contrast, does not generally get any favorable tax treatment. Individual market insurance costs are not typically excluded from taxable income; a woman can deduct the cost of this type of insurance policy only if the coverage costs (along with all other out-of-pocket medical expenses) exceed 7.5 percent of her income.

- A woman who is **self-employed** can deduct the full cost of an individual market insurance policy from her income tax, provided that she does not have access to ESI through her own or a spouse's employer. Her health benefits, however, are still subject to a payroll tax.

- Individuals and their employers also receive tax breaks on funds contributed to certain types of savings accounts that can be established to pay for health care, such as **Flexible Spending Accounts (FSAs)** which allow workers to set aside a fixed amount of their annual salary on a tax-free basis, or **Health Savings Accounts (HSAs)**, tax-free accounts for individuals enrolled in high-deductible health plans.[3]

How Would Health Reform Proposals Change the Tax Code in Ways That Encourage More Women to Purchase Coverage?

In their health care reform plans, several 2008 presidential candidates proposed new tax credits for individuals and families to purchase health insurance from an employer-sponsored plan or through the individual insurance market. One proposal, for example, would have provided a flat tax credit of $2,500 for individuals or $5,000 for a family. Another plan would have incorporated a tax credit for low- and moderate-income families, with credit amounts determined by an income-based sliding scale.

Other proposals offer different ways to equalize the tax treatment of health coverage among people that get ESI and those who purchase insurance from the individual market. These reforms might limit or completely eliminate the current tax break that workers and employers receive on job-based health insurance by including the value of ESI benefits as taxable income and establishing a new standard tax deduction or tax credit in place of the current tax break. For instance:

- The Bush Administration has proposed to eliminate the existing tax exclusion for employer-based coverage and replace it with a standard tax deduction ($7,500 for individuals and $15,000 for a family) that would be available to anyone who purchases private health insurance, whether from their employer or the individual insurance market.
- The Tax Equity and Affordability Act of 2007 (S. 397), sponsored by Senators Martinez (FL) and Coburn (OK), would cap the current tax exclusion for employer-sponsored health benefits at $5,000 for individual or $11,500 for family coverage.

Alternatively, proposals could leave the current ESI tax breaks intact and create a new tax deduction for coverage purchased through the individual market, such as:

- The Health Care Equity Act (S. 2835), sponsored by Senators DeMint (SC) and Kyl (AZ), which would allow those purchasing coverage through the individual insurance market to deduct their health premiums from income taxes.

What Limitations Are Associated with Tax-Based Health Reform Proposals?

For various reasons, health reforms that would change the federal tax code are limited in their ability to improve women's access to high-quality, affordable health coverage.

Many health reform tax proposals would encourage women to buy their coverage through the individual (non-group) insurance market, which has many flaws. Health reform proposals that eliminate the tax advantages associated with employer-based coverage and provide new tax incentives for women to purchase coverage on their own will encourage more women, in effect, to buy coverage directly from insurers through the individual insurance market. Yet this market presents many challenges for women and their families. Consider the following facts:

- In most states, individual market insurers are permitted to charge people more for health premiums based on factors such as age, gender, or health status. Women with even a minor health condition may have difficulty obtaining an affordable insurance policy in the individual insurance market, or insurers may deny coverage altogether for women with health problems.[6]
- Individual insurance policies generally require a greater level of out-of-pocket spending. They may involve high deductibles, coinsurance, and copayments at the point of service (in addition to the required monthly premiums), or they may offer a limited benefit package so that women are required to pay out-of-pocket for the costs of care that is not covered. In 2004, people with individual insurance coverage paid an average of 55.3 percent of total health expenditures out-of-pocket, compared to 31.9 percent for people with group coverage.[7]

What Is the Difference Between a Tax Credit and a Tax Deduction?

Over half of all uninsured people are not eligible for public coverage programs, yet they still cannot afford to purchase private health insurance.[4] Tax credits and tax deductions are government subsidies that are used to offset the costs of health insurance and encourage more individuals to buy private coverage. These two mechanisms function differently:

- A **tax credit** reduces the amount of taxes paid, so that for every $1 a woman receives in tax credits, the amount of taxes she owes is reduced by $1. Tax credits can be structured to include three important features:

  - A refundable tax credit is available even to very low-income women with limited or no tax liability; regardless of whether she owes taxes, she will get full cash value of the tax credit through a refund.
  - An advanceable tax credit is "forward funded," or made available to a woman at the beginning of a year so that she can use it whenever her health insurance premium is due.
  - An assignable tax credit is directly and automatically paid to the health insurance company.

  These three features are particularly important to include in tax credit proposals because they will enable low-income recipients with limited cash resources to purchase health insurance policies.

- A **tax deduction** reduces a woman's gross income, lowering her overall taxable income and thus lowering the amount of taxes she owes. Rather than a dollar-for-dollar reduction in taxes owed, the value of a deduction depends on the woman's income tax rate. For example, for each $1 deducted, a woman in the 35 percent tax bracket would save $0.35 and a woman in the 10 percent tax bracket would save $0.10.

What refundable tax credits and tax deductions have in common is that they are both contingent on an individual's income. But millions of Americans, especially single mothers and elderly women, have incomes too low to owe any federal income taxes.[5] In the most general sense, proposals that rely on the tax system have limited ability to reach the low-income uninsured. Tax deductions, in particular, hold little benefit for those women who already owe little or no taxes; what advantage will they gain by further lowering their gross income, since they owe minimal or no taxes to begin with? Moreover, tax deductions require a woman to pay up-front for health benefits during the year and then deduct that spending later, when taxes are filed; this may be difficult or even impossible for lower-income families to manage.

In contrast, refundable, advanceable, and assignable tax credits are more likely than tax deductions to benefit individuals in lower- and middle-income brackets, but credits would need to be large enough to cover premiums and out-of-pocket health care spending to effectively increase health care coverage for poor women. It is also critical that any health insurance premium subsidy—whether a tax credit or a deduction—continues to increase over time in order to keep up with the growth in health care costs.

- Individual health policies often do not include the comprehensive benefits that women need. Limitations on certain benefits such as prescription drugs or mental health services are common, and maternity care is usually not covered at all. Individual market insurers frequently sell pregnancy-related benefits under a separate "rider" at additional cost, but this coverage is often limited in scope or may only be used after a significant waiting period.[8]

Unless tax proposals are combined with individual insurance market reforms or options to buy into group insurance, they are unlikely to help low-income uninsured women purchase meaningful coverage.

Health reforms that change the federal tax code could threaten the security of employer-based health insurance. If the tax benefit for job-based coverage did not exist, some employers would likely elect to stop offering coverage altogether. Analyses of proposals that would replace the tax exclusion for employer-based coverage with a new standardized tax-based health subsidy estimate that this type of reform could result in the loss of job-based coverage for between 12 million and 20 million workers (depending on proposal details); this loss would be concentrated among medium and small-sized firms.[9, 10]

New tax incentives might also encourage some workers currently covered by employer-sponsored insurance to seek health insurance outside of the workplace. If the value of a tax incentive is greater than the subsidy available through an employer, healthier workers may leave job-based coverage to enroll in an individual market plan. This shift would break up the group of people covered under ESI, since sicker workers—who, by nature of their health status would have fewer or no options in the individual market compared to their healthier counterparts—would remain in job-based coverage. If ESI plans lack a healthier, lower-risk population to help spread the costs of higher-risk enrollees, premiums for those plans could become unaffordable.

Tax-based subsidies may be inadequate for the purchase of high-quality, comprehensive health insurance coverage with affordable cost-sharing requirements. Many tax credit proposals fall far short of the actual total cost of health insurance. In 2005, the average premiums for a non-group health insurance policy were $3,664 for an individual and $5,568 for a family.[11] These averages do not represent the *total* health spending required of enrollees—since health insurance policies sold in this market typically require significant out-of-pocket costs such as deductibles, coinsurance, and copayments in addition to premiums—nor do they account for the great variation in the benefit levels of the policies. In addition, these estimates do not reflect the fact that most insurance companies are allowed to charge individuals more for a policy based on factors like health status, gender, and age.

Consider the results of a 2004 study to determine the average premium cost for a "standard" health insurance plan (similar to plans offered to federal workers through the Federal Employees Health Benefits Plan). The study reported an annual premium of $5,780 for a healthy, non-smoking 55 year-old woman; $3,536 for a 40 year-old woman; and $2,403 for a 25 year-old woman.[12] A tax credit of $2,500 may be sufficient for a 25 year-old woman to purchase a standard health insurance plan, but the same credit would barely cover half the cost of a standard health insurance plan for her 55 year-old counterpart.

Low-income people are not likely to be able to make up the difference between the credit amount and the cost of an adequate insurance policy. When tax credits fall short, poor women

may be forced to choose between purchasing a health plan that fits the credit amount and redirecting a portion of her limited household resources to supplement a plan that actually fits her needs. If women obtain insurance that is inadequate, such as a plan that requires unaffordable deductibles or a bare-bones plan with very limited benefits, a situation of underinsurance results, leaving women vulnerable to financial risk and unmet health needs.

Tax proposals may do little to reduce the number of uninsured women. Poor or near-poor women are particularly at risk for being uninsured.[13] But tax deductions, which reduce a woman's taxable income, are unlikely to benefit low-income women because they have little or no tax liability in the first place. Tax deductions, therefore, are not likely to significantly reduce uninsurance rates; an analysis of the Bush Administration's tax deduction proposal estimated that it would only reduce the ranks of the uninsured by about one-fifth.[14]

While a refundable, assignable, and advanceable tax credit is more likely than a tax deduction to help low-income uninsured women obtain health coverage, health policy experts question whether even this type of reform would be successful in expanding health coverage in any meaningful way.[15] The credit would benefit those people who are already purchasing health insurance on their own, but there is no evidence that such a policy would actually encourage currently uninsured people to obtain health coverage. For instance, how would a tax credit help improve access to care for a woman who is otherwise "uninsurable" because of her health status? The credit itself will do little good if insurance companies will not offer her an affordable policy, or if they will only issue a policy that excludes coverage for her pre-existing health conditions.

Lessons from the Health Care Tax Credit Program

The U.S. has little experience with using tax credits to cover the uninsured, and so there is limited evidence of their effectiveness in increasing coverage. The Health Care Tax Credit (HCTC) program—enacted as part of the Trade Assistance Adjustment Reform Act of 2002—provides a single example of an existing health insurance tax credit policy. The program provides a refundable tax credit (covering just 65 percent of the cost of premiums for health coverage) to a limited number of individuals, including workers who lost their jobs due to the North American Free Trade Agreement (NAFTA).

Only 15 percent of eligible individuals participate in the HCTC. Low participation rates are related to the program's complex enrollment processes, eligible individuals' inability to find a "HCTC-qualified" benefit plan that cover their needs, or—even when a qualified plan is available—their inability to afford the remaining 35 percent of insurance premiums. In addition to these issues, extremely high administrative costs (accounting for over a third of the total program costs) make the HCTC a bad deal.[16]

What Can Women's Advocates Do?

Women's advocates can support proposals that use mechanisms other than the federal tax code to expand health care coverage.

In general, health reforms involving changes to the federal tax code are limited in their ability to increase coverage among low-income people (who account for a majority of uninsured

Americans). Unless tax incentives are structured in ways that would allow poor women and their families to purchase health coverage, and unless they are combined with reforms to the individual insurance market, they are unlikely to solve America's health care crisis.

However, if women's advocates must work with a reform proposal that relies on a tax mechanism to expand coverage, there are certain actions that they can take to make tax-based health reforms more acceptable. They can:

- **Promote tax credits over tax deductions, and ensure that tax credit proposals include features that would enable low-income uninsured women to purchase health coverage.** Tax deductions lower an individual's taxable income and provide greater benefits to higher-income people. Tax credits are generally more advantageous for lower-income women and their families. In addition, certain features—such as mechanisms to make tax credits refundable, advanceable, and assignable—make it more likely that low-income people with little or no tax liability will be able to use the credits to purchase health coverage for themselves and their family members.
- **Promote health reforms that would make individual market health insurance more accessible for all women, including those who are older or who have a pre-existing medical condition.** These reforms include but are not limited to: mergers of the individual and small-group insurance markets (which spread medical costs among a larger group of insured people), community rating, or limiting how long individual market health insurers can exclude coverage for a pre-existing condition.[17]
- **Promote health reforms that would ensure that women have access to an adequate package of health benefits.** Reforms that impose a minimum standard for health benefits or that require health insurers to offer at least one standardized minimum benefit plan may make it easier for women to purchase health coverage that meets their needs. These reforms should be combined with adequate subsidies so that comprehensive coverage is more affordable for low-income women.

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1 Health benefits for employees and qualified spouses and dependents are not taxed as income by federal and state governments. However, health benefits for employee's domestic partners are taxed as income by the federal government and in a majority of states. See the "Domestic Partner Health Insurance Benefits and Tax Policy" section of the *Reform Matters Toolkit* for a more detailed discussion of this issue.

2 National Women's Law Center analysis of 2007 data on health coverage from the 2008 Current Population Survey's Annual Social and Economic Supplement , using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html.

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11 Didem Bernard, PhD and Jessica Banthin, PhD, Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey (MEPS) Statistical Brief # 202: Premiums in the Individual Health Insurance Market for Policyholders under Age 65: 2002 and 2005* (Apr. 2008), http://www.meps.ahrq.gov/mepsweb/data_files/publications/st202/stat202.pdf.

12 Families USA, *A 10-Foot Rope for a 40-Foot Hole: Tax Credits for the Uninsured, 2004 Update* (Nov. 2004), http://www.familiesusa.org/assets/pdfs/10_Foot_Rope_update_2004804d.pdf.A "standard" plan was defined as one that enables a consumer to receive adequate health care with a reasonable level of cost-sharing. Standard plans had to meet certain requirements for cost-sharing, such as not having a deductible higher than $250, or coinsurance rates for inpatient and outpatient services that were higher than 20 percent.

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15 Ellen Meara et al., Employment Policies Institute, *Comparing the Effects of Health Insurance Reform Proposals: Employer Mandates, Medicaid Expansions, and Tax Credits* (Feb. 2007), http://www.epionline.org/study_detail.cfm?sid=104.

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Domestic Partner Health Benefits and Tax Policy

Nearly 6 million Americans live together as unmarried partners.[1] Currently, the federal tax code treats health benefits for unmarried and married partners differently, contributing to higher rates of uninsurance among those couples who are unmarried.[2] Comprehensive health reform must include efforts to revise federal and state policies that unfairly tax health benefits for unmarried partners.

Health Insurance for Domestic Partners: Same Benefits, Different Tax Treatment

Most nonelderly women, and most Americans in general, get their health care coverage tax-free from an employer. In the United States, most women with health insurance are covered through an employer-sponsored health plan. In 2007, 39 percent of nonelderly women were covered through their own employer's plan and another 25 percent were covered as spouses or dependents under a family member's employer-sponsored plan. [6]

The majority of employers who offer health insurance to their employees also offer health insurance for the employees' spouse and children. Like the job-based coverage an employee receives, coverage for a spouse or dependent child is not taxed because it is not considered employee income by the state or federal government. This means that employees receive a double benefit – health insurance for the people they care about, on a tax-free basis.

But workers with unmarried domestic partners are unlikely to receive an employer offer of health coverage for their partner; those who can get

What Is a Domestic Partnership?

A domestic partnership is a legal or personal relationship between two individuals who live together and share a common domestic life but are not joined by a traditional, government-sanctioned marriage. The federal government does not currently recognize domestic partnerships, but as of June 2008, 9 states—California, Connecticut, Hawaii, Maine, New Hampshire, New Jersey, Oregon, Vermont, and Washington—and the District of Columbia provided relationship-recognition structures for domestic partners, typically through laws that allow civil unions or that establish domestic partner registries.[3,4]

The majority of the above states have instituted these structures as a way to recognize same-sex unions, though some states' laws apply to both same-sex and opposite-sex couples. Additionally, Massachusetts and Connecticut[5] offer same-sex couples all of the state-level rights and benefits of marriage, and New York recognizes marriages by same-sex couples legally entered into in another jurisdiction.

Regardless of whether their state formally recognizes such relationships, employers may choose to offer health benefits to workers' domestic partners. Employers themselves can determine the criteria for a domestic partnership, including whether same-sex couples and/or opposite-sex couples qualify. For example, an employer may determine eligibility for domestic partner benefits by requiring employees to sign an "Affidavit of Domestic Partnership" and show proof of their partnership, such as evidence of joint purchase and ownership of a home.

benefits for their partners do not receive the same federal tax benefits as their married coworkers. In contrast to their married coworkers, employees with unmarried domestic partners do not receive the aforementioned "double benefit." An overwhelming majority of American employers—roughly three out of four—do not offer health benefits to the domestic partners of their workers; employees of small businesses are especially unlikely to get an offer of domestic partner health benefits.[7]

Even if a worker is able to get health benefits for her domestic partner through her employer, her partner's coverage does not receive the same favorable tax treatment as coverage for spouses and children. Domestic partner health benefits are treated like income by the federal government and most states, and are taxed as if the employee received a raise in salary for the value of the health coverage.

Because of this unequal tax treatment, workers who get job-based health insurance for their domestic partners pay an average of $1,069 more per year in federal taxes than their married counterparts who get the same coverage for spouses or children. Collectively, unmarried partners spend roughly $178 million per year in additional federal income taxes.

This unequal tax treatment also provides a disincentive for employers to offer coverage for domestic partners. Because partner coverage counts as employee income and raises the firm's total payroll, employers pay more in payroll taxes when they cover partners versus other family members. U.S. employers pay an estimated $57 million per year in additional payroll taxes because of this situation.[8]

State Tax Laws and Domestic Partner Benefits

The majority of states generally follow the federal lead on tax policy, but a handful of states have adopted tax laws that give domestic partner health insurance benefits the same favorable tax treatment as other job-based dependent coverage. For example, some of the state relationship-recognition laws referenced on the previous page influence how domestic partner health benefits are taxed. In those states where domestic partner health benefits are treated differently by federal and state tax systems, employers and employees must calculate income in several different forms based on state guidelines and then based on federal guidelines.[9]

Federal Proposals Related to Domestic Partner Health Benefits

Though the federal government has not yet taken any actions that would improve circumstances for workers with domestic partners, two notable health reform proposals have been introduced in Congress that would benefit couples in domestic partnership arrangements:

- The Tax Equity for Domestic Partner and Health Plan Beneficiaries Act (S. 1556), sponsored by Senator Gordon Smith (OR), would eliminate the unequal tax treatment of domestic partner benefits so that the value of these benefits would be excluded from their federal income tax.
- The Domestic Partnership Benefits and Obligations Act (H.R. 3848), sponsored by Representative Tammy Baldwin (WI), would provide domestic partnership benefits (including retirement, life insurance, and health benefits) to all federal civilian employees on the same basis as spousal benefits. The legislation would allow domestic partners of eligible federal employees to get coverage through the Federal Employees Health Benefits Plan (FEHBP), which is the largest employer-sponsored health insurance program in the country. The FEHBP currently covers about 8 million federal employees, retirees, and their dependents through contracts with private insurance plans.[10]

What Can Women's Advocates Do?

The current tax treatment of domestic partner health benefits is unjust and makes it more difficult for domestic partners to obtain job-based health coverage. Individuals living as unmarried couples are two to three times more likely to have no health coverage than their married counterparts.[11] As the nation considers proposals to expand coverage to the swelling ranks of the uninsured, flawed policies that make it more difficult and more expensive for millions of hardworking Americans to get employer health benefits for their partners will only make the situation worse.

Women's advocates can support federal and state legislation that would treat domestic partner health benefits the same as spouse and family coverage.
Such legislation will prevent families headed by domestic partners from paying more in taxes than their married counterparts. It will also eliminate a financial disincentive for employers to offer health coverage to domestic partners, and therefore could increase the number of employers offering this coverage.

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Addressing Health Care Costs: An Essential Part of Health Reform

It is impossible to have a serious discussion about health reform without considering the growing cost of health care. Health-related spending grows on an annual basis, often outpacing spending on the other goods and services that make up the United States economy. Those responsible for paying for health care—the government, employers, and families alike—increasingly feel the financial squeeze of uncontrolled health care inflation. Confronted with rising health care costs, a growing number of employers may find that they cannot afford to provide health insurance for their workforce, and more and more families may not be able to afford to purchase coverage. Simply put, any attempt at expanding coverage for all will be short-lived if health care costs are not controlled.

Women's advocates encounter both challenges and opportunities when considering how cost control fits into progressive health reform. Some health reform plans that aim to control costs may only shift more of the burden of health care costs to health plan enrollees, making it more difficult for families to afford health care when they need it. Or, federal and state government attempts to control the costs of publicly-funded health coverage programs may result in the loss of basic health benefits for the nation's most vulnerable populations. Advocates must work to ensure that cost containment does not come at the expense of access to high-quality and affordable health care for women and their families. Cost control initiatives, however, also present an opportunity for health system improvements that can result in the delivery of more efficient and higher-quality care. If implemented carefully, health reforms that address growing health care costs can ensure that health system improvements are sustained in the future.

Why Must We Consider Health Care Costs?

Health care costs are skyrocketing, and their growth far outpaces that of workers' wages. Health care costs continue to increase faster than incomes, and families spend more out-of-pocket each year for their health insurance premiums and for health care services.[2] Health insurance premiums, for instance, grew by 78 percent between 2001 and 2007, compared to wage growth of just 19 percent.[3] Rising health care costs place a growing burden on families. In 2007, about 57 million Americans lived in families that reported problems paying medical bills, an increase of more than 14 million since 2003. Most of those people had insurance coverage. They reported challenges with paying for other basic necessities such as food, housing, and clothing, and they also reported much higher levels of unmet medical need than families without medical bill problems.[4]

Who Pays for Growing Health Care Costs?

While Americans may believe that their employers feel the greatest squeeze from increasing health care costs, economists generally agree that the growing cost of health care is coming out of employee wages in a cost-wage trade-off. In other words, the rising cost of health insurance coverage has led to smaller wage increases. Over the last 30 years, while health insurance premiums have grown by 300 percent, after-tax corporate profits have grown by 200 percent and average hourly wages for employees have actually *decreased* by 4 percent.[1]

Addressing costs is essential for a sustainable health system, and for the solvency of publicly-funded health programs.

In 2005, health care accounted for 16 percent of the nation's gross domestic product (or GDP, a common measure of national economic activity). By the year 2016, health spending is projected to account for nearly 20 percent of the GDP.[5] If health care costs continue to grow rapidly, more and more employers and individuals will find themselves priced out of the health insurance market, and unable to afford coverage at all. Moreover, the state and federal governments that pay for nearly half of all health care spending will not be able to sustain the public coverage programs they administer—including Medicare, Medicaid, and the State Children's Health Insurance Program—if costs are not contained. Or, if the costs of public coverage programs continue to consume ever larger shares of state and federal budgets, other areas of government spending, such as education or transportation, will suffer from reduced resources. Policymakers may propose cuts to public program eligibility levels (so that fewer people qualify for and enroll in the programs) as a way to address the problem of rising health care costs, but these types of cost containment measures are not acceptable health reform since they will result in greater numbers of low-income women and families without access to the health care they need.

Addressing costs can lead to a less wasteful and more efficient health care system.

Spending more on health care does not guarantee better care. Indeed, though Americans spend more almost twice as much per capita (over $6,500 per person in 2005) on health care as citizens of other developed countries, their health is no better and in many cases is worse in comparison to these countries. As much as 30 percent of health care spending, or roughly $700 billion, is considered wasteful because it has no value to the patient and does not improve health outcomes. Indeed, at a July 2008 Congressional hearing on getting better value out of health care, the Director of the Congressional Budget Office (CBO) declared that "health care is the least efficient sector of our economy."[6]

Cost control is inextricably linked to health care access and health care quality.

The savings that result from thoughtfully-implemented cost containment initiatives can be diverted to expanding access to health care for greater numbers of uninsured people, financing new coverage programs, or making improvements to the health infrastructure. Moreover, the savings from cost containment can lead to improved quality because—as detailed below—reform initiatives that control costs are also those that result in the delivery of more efficient health care.

Why Are Health Care Costs Increasing?

Health care costs are increasing for a number of interrelated reasons, including, but not limited to:

- **Growth in health care technologies.** Most health economists and analysts point to major advances in medical science as the primary factor contributing to the growth of health care spending in recent decades. The emergence, adoption, and widespread diffusion of costly new drugs, medical equipment, and skills have increased health care spending overall.[7]

- **Increasing life expectancy and incidence of chronic diseases.** Since average medical spending typically increases with a person's age, as the United States population ages and average life expectancy increases, health spending rises. Spending projections, however, indicate that an aging population will have only a modest effect on national

health care spending.[8] The burden of chronic disease also affects health care costs, since people with chronic conditions such as diabetes, asthma, and heart disease are likely to have significantly higher average healthcare costs than people without them. As the incidence of certain chronic conditions increases, so do overall health care costs.

- **The current health care financing structure.** In the current U.S. health care system, health care providers are generally paid according to the volume and intensity of the services they deliver, rather than whether or not they keep patients healthy. This approach may not benefit health consumers, providers, or the system overall, since it provides an incentive for unnecessary care and costs.

- **Growth in health care insurance industry profits.** Between 2000 and 2005, the insurance industry's administrative expenses (i.e. costs of marketing, medical underwriting, claims processing) and profits increased by 12 percent per year. This is considerably faster than the growth rate for overall health spending during that time period. The consolidation and concentration of market power in the insurance industry over the past several years—in addition to major increases in the market share of the biggest health insurers and higher profit margins—have contributed to the steady growth of health care costs.[9]

What Are Some Ways That Health Reform Plans Can Contain Costs?

- **Health reform plans can incorporate initiatives that will improve health care quality.** High-quality health care is, simply put, the right care, at the right time, for the right reason. Health reform provisions that improve the quality of health care that women and their families receive also have the potential to reduce health care costs. These include health reforms that promote chronic disease management, and reforms that revise health care payment systems so that providers are encouraged to manage care more effectively for better health outcomes. For instance, a "pay-for-performance" pilot program administered by the Centers for Medicare and Medicaid Services (CMS) pays physicians participating in the Medicare program based on the quality and efficiency of the care they provide. The program has reported promising results, showing gains in quality of care to patients with congestive heart failure, coronary artery disease, and diabetes. Importantly, the program also reduced CMS spending.[10] The "Ensuring Quality Health Care in Health Reform" section of the *Reform Matters Toolkit* explores initiatives to improve health care quality in greater detail.

- **Health reform plans can emphasize preventive and primary care.** By accessing timely preventive health services—such as immunizations, cancer screening services, or annual physical examinations—women and their families can avoid the development of more complicated and costlier health problems in the future. To encourage patients to seek the appropriate care at the appropriate time, health reform plans might incorporate "value-driven" health benefit designs that better align patient and provider incentives, by eliminating or reducing copayments for preventive and essential medical services and medications, while requiring higher copayments for specialized services that are subject to overuse.[11]

- **Health reform plans can include initiatives that promote the widespread use of health information technology (HIT).** HIT, or the use of computers and other electronic devices to manage health information, can reduce medical errors and improve coordination of health care among providers, thereby enhancing not only the

Emphasizing Preventive Care to Improve Health and Save Costs.

In their 2007 report *Preventive Care: A National Profile on Use, Disparities, and Health Benefits*, the Partnership for Prevention highlights the fact that effective preventive care is significantly underutilized in the United States, which results in lost lives, poor health, and inefficient use of health care dollars. The report ranks several clinical preventive health services according to their cost effectiveness, measured as the health service's return on investment (the cost of a service compared to its health benefits). The most cost-effective preventive services include:

- Childhood immunizations
- Advising at-risk adults for daily aspirin use
- Smoking cessation advice and help to quit for adults
- Alcohol screening and brief counseling for adults
- Colorectal cancer screening for adults age 50 and over
- Influenza immunization for adults age 50 and over
- Vision screening for adults age 65 and over

By increasing use of just five of the preventive services examined in the report, the Partnership for Prevention estimates that 100,000 lives could be saved. More widespread preventive care would also result in the more effective use of national health resources since the country would get more value—in terms of premature death and illness avoided—for the money it spends on health care.[12]

quality but the effectiveness of care. Some analysts believe, however, that while incorporating HIT into the health care system will save costs and improve efficiency, HIT initiatives alone will only result in modest cost savings.[13] These types of reforms must be coupled with other efforts to slow the growth of health care costs. The "Health Information Technology: A Key Component of Health Reform" section of the *Reform Matters Toolkit* explores HIT in greater detail.

- **Health reform plans can support the role of public coverage programs as a way to expand access to health insurance, including the creation of a public health plan option for individuals and employers.** One recent study indicates that total medical spending is much lower when coverage is provided by public health insurance programs such as Medicaid or SCHIP than when it is provided by private insurance. The study authors conclude that "efforts to expand coverage for low-income populations, whether conducted at the national or state level, would be less costly to society and much less costly to financially strapped beneficiaries if the expansions were based on public insurance like Medicaid and SCHIP."[14] Moreover, a publicly-sponsored health program that competes on a level playing field with private health insurance companies for enrollees may result in lower administrative costs, reduced health care industry profits, and greater choice and competition among plans.[15]

Why Must Women's Advocates Approach Cost Containment with Caution?

To ensure that health reform plans do not harm access to health care, reforms to control cost must be considered carefully. Some health proposals that seek to control costs may diminish important health consumer protections or simply shift more costs onto women and their families. These include proposals that allow insurance companies in the individual and small group markets to sell bare-bones health plans (i.e. plans that are exempt from critical

mandated health insurance benefits) offering limited health coverage, as well as so-called "consumer-directed health care" plans, which combine high-deductible health plans with tax-free health savings accounts (HSAs).[16]

Lessons from the States:

Opportunities and Challenges Posed by Rhode Island's Cost Control Reforms.

In 2008, Rhode Island Lieutenant Governor Elizabeth Roberts introduced a comprehensive health reform package, the Healthy Rhode Island Reform Act of 2008. Though the reform package includes some provisions to establish a universal coverage system similar to that of neighboring Massachusetts, early news reports on the Rhode Island plan distinguished the state's efforts as stressing costs as much as coverage, stating that the "plan acknowledges that Rhode Island cannot afford, financially or politically, to insure all its residents unless it can deliver healthcare more efficiently and raise money through a tax on businesses that do not provide coverage."[17] One component of the reform legislation that has already been enacted, for example, involves a statewide Chronic Care Management Program, which aims to identify eligible patients, ensure that each chronic care patient has a designated primary care provider, coordinate care among health providers, and monitor performance by establishing process and outcome measures for program participants.[18]

But with the same aim to control costs, Rhode Island has also applied for federal permission to transform its state Medicaid program into a block grant, whereby the state would receive an annual fixed amount for Medicaid with no additional federal funding to address unanticipated health care cost increases or enrollment.[19] In exchange for accepting the block grant, Rhode Island seeks unprecedented flexibility to manage the costs of Medicaid. If approved, the state's proposal would eliminate a number of federal protections for Medicaid beneficiaries, allowing the state to make significant changes to its program without federal oversight. Many of Rhode Island's most vulnerable families would be at risk of losing coverage and services.[20]

These two different cost containment approaches in Rhode Island demonstrate both the opportunities and challenges that women's advocates encounter when considering reforms that address health care costs.

What Can Women's Advocates Do?

Women's advocates can understand the role of costs in health reform, and ensure that reform plans address growing health care costs without harming women's access to high-quality health care.

Addressing health care costs presents a significant challenge for health reformers, as potential interventions may require new approaches to health care delivery and the establishment of new information systems. Advocates are further challenged to ensure that cost control does not harm access to health care for women and their families. Ultimately, however, health care reform that is realistic and sustainable **must** include provisions to control the growth of health care costs. In the absence of these provisions, the nation's foundation of employer-sponsored insurance will continue to erode, and women and their families will continue to struggle to afford high-quality health coverage.

For further reading, see:

Kaiser Family Foundation, *Health Care Costs, A Primer: Key Information on Health Care Costs and Their Impact* (Aug. 2007), http://www.kff.org/insurance/upload/7670.pdf

National Conference on State Legislatures, *State Health Care Cost Containment Ideas* (July 2003), http://www.ncsl.org/programs/health/healthcostsrpt.htm

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2 Jessica S. Banthin, et al., *Financial Burden of Health Care 2001-2004*, Health Affairs 27(1) (2008); Cathy Schoen et al. How many are Underinsured? Trends among U.S. Adults, 2003 and 2007, Health Affairs web exclusive (2008), http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.4.w298

3 Kaiser Family Foundation, *Employer Health Insurance Costs and Worker Compensation* (Mar. 2008), http://www.kff.org/insurance/snapshot/chcm030808oth.cfm

4 Peter J. Cunningham, Center for Studying Health System Change, *Trade-Offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003-2007* (Sept. 2008), http://www.hschange.com/CONTENT/1017/

5 Kaiser Family Foundation, *Health Care Costs, A Primer: Key Information on Health Care Costs and Their Impact* (Aug. 2007), http://www.kff.org/insurance/upload/7670.pdf

6 U.S. House of Representatives Budget Committee, *Getting Better Value in Health Care* (Sept. 2008), http://budget.house.gov/doc-library/fy2009/2008-0716better-value-in-healthcare-summary.pdf

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8 *Id.*

9 Karen Davis et al., The Commonwealth Fund, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?* (Jan. 2007), http://www.commonwealthfund.org/usr_doc/Davis_slowinggrowthUShltcareexpenditureswhatareoptions_989.pdf?section=4039

10 Kaiser Family Foundation, *CMS Pay-for-Performance Pilot Has Improved Quality of Care, Lowered Costs* (Aug. 2008), http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=53991

11 Michael Chernew, et al., *Rising Out-of-Pocket Costs in Disease Management Programs*, American Journal of Managed Care 12(3):150–54 (Mar. 2006).

12 Partnership on Prevention, *Preventive Care: A National Profile on Use, Disparities, and Health Benefits* (Aug. 2007), http://www.prevent.org/index2.php?option=com_content&do_pdf=1&id=129

13 Bureau of National Affairs, "CBO Head Says Health Costs Hurt Today, Issue Not Linked Only to Generational Equity" (May 14, 2008).

14 Leighton Ku and Matthew Broadus, *Public and Private Health Insurance: Stacking Up the Costs*, Health Affairs web exclusive (Jun. 2008), http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.4.w318v1

15 John Holahan and Linda Blumberg, The Urban Institute, *Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?*, (2008), http://www.urban.org/UploadedPDF/411762_public_insurance.pdf

16 Other sections of the *Reform Matters Toolkit* describe these types of reforms and the harmful effects they may have on women and their families.

17 Alice Dembner, *Care, cost stressed in R.I. initiative,* The Boston Globe (February 13, 2008), http://www.boston.com/news/local/rhode_island/articles/2008/02/13/care_cost_stressed_in_ri_initiative/

18 The Healthy Rhode Island Reform Act of 2008, "Health and Safety" § 1.23, Chapter 17.21.

19 Currently, the federal government matches state Medicaid expenditures at a fixed rate, but without a fixed limit.

20 Judith Solomon, Center on Budget and Policy Priorities, *Rhode Island's Medicaid Proposal Would Put Beneficiaries at Risk and Undermine the Federal-State Partnership* (Sept. 2008), http://www.cbpp.org/9-4-08health.htm

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