

Raising Women's Voices for the health care we need

A collaborative initiative of the Avery Institute for Social Change,
the MergerWatch Project of Community Catalyst
and the National Women's Health Network

FACT SHEET No. 1

End insurance company practices of denying coverage to people with pre-existing conditions!

Did you know that if you are trying to buy health insurance on your own – instead of getting it through an employer – you could be turned down or charged more if you have cancer, diabetes, arthritis or other conditions? Or that you could be refused because you are pregnant?

Many states allow insurance companies to exclude people with what are known as “pre-existing conditions.” If the insurer does issue a policy to someone with a pre-existing condition, it may be permitted to charge a higher premium or attach an “exclusionary rider” to rule out covering any treatment of the condition for a waiting period or the entire duration of the policy.

What are some examples of “pre-existing conditions” that affect women?

For women, the list of pre-existing conditions, amazingly, can include being pregnant or even having had a cesarean section delivery. *The New York Times* reported recently¹ that the Golden Rule Insurance Company, which sells individual health insurance policies in 30 states, will only sell insurance to a woman who has had a cesarean delivery if it could exclude paying for another one for three years, or if the woman had been sterilized. Blue Cross Blue Shield of Florida told the newspaper it charges 25 percent more for individual health insurance for five years if a woman has had a c-section (unless she has since been sterilized).

Even taking medications such as Celebrex for arthritis pain or Nexium for heartburn can disqualify you for an individual health insurance policy in some states, according to a new report from Families USA.¹ People who work in places where they might be injured can also be excluded from eligibility for individual insurance coverage.

How widespread is this practice?

Excluding people with pre-existing conditions, charging them much higher premiums, or refusing to cover specific pre-existing conditions are all very widespread practices, according to Families USA. “Only five states prohibit insurance companies from ‘cherry-picking’ the healthiest consumers and excluding everyone else from coverage,” the group reported. The report found that 21 states and the District of Columbia allow insurers to refuse to cover pre-existing conditions, such as cancer and heart ailments, for more than one year after you sign up for a plan. The survey found that thirty-five states and the District of Columbia allow insurance companies to charge more to people based on their health status. According to Kaiser State Health Facts, only 12 states prohibit insurers from selling policies that contain **elimination riders**—clauses that say that the insurer will *never* cover an individual’s treatment for a specific condition.

Even if they do issue you a policy, insurers often do not explain what they will and will not cover. In 29 states and the District of Columbia, insurers can dig back through your medical history and refuse to pay for treatment by claiming you failed to disclose a pre-existing condition.

How many people need to buy their own health insurance? About 14 million non-elderly people in the United States bought individual health insurance policies in 2006.² That number is expected to grow over the

next few years as more employers drop health coverage for their employees to cut costs and public policymakers promote the use of tax credits or tax-deductible “health savings accounts” to encourage people to buy their own health insurance.

Do these problems affect people who get health insurance through their employers? Generally, no. A federal law, the Health Insurance Portability and Accountability Act (HIPAA), prohibits employer-sponsored health plans from refusing you coverage or charging you more if you are sick or have a pre-existing condition. There are a few exceptions, however. If you enroll in an employee health insurance plan and have not had health coverage for at least the last 12 months, even your employer-sponsored health plan may refuse to cover treatment of your illness for up to one year.³

In addition, when a very small employer tries to buy group coverage for its few employees, many states allow insurance companies to review the health status of employees in the group and then charge a higher premium rate for the firm based on employees’ pre-existing conditions. If this happens, the cost of the coverage may be so expensive that the employer decides not to offer it.

Are people with public insurance, such as Medicaid or Medicare, affected?

No. These public insurance programs do not permit denial of coverage for pre-existing conditions. However, when people lose eligibility for Medicaid and then try to buy individual policies, they may find themselves without coverage for needed services.

What can be done about this problem?

The most comprehensive approach to solving this problem is to enact health reform that guarantees everyone affordable, quality health coverage that is available whether you are healthy or sick. In fact, recent public opinion research has found that the single most compelling reason why women voters want guaranteed affordable choice of a health plan for everyone is that insurers would not be able to deny coverage to people with pre-existing conditions.⁴

If comprehensive health reform is not politically feasible in your state, several incremental steps are needed:

1. Fight for public policies requiring insurance companies to sell individual policies to anyone who seeks one, regardless of their health, income, age or other factors. Such policies are known as **“guaranteed issue” laws**. Only five states have these laws: Maine, Massachusetts, New Jersey, New York and Vermont.⁵ Seven states prohibit insurers from charging higher premiums to people with pre-existing conditions. Many states have established alternative coverage (“high-risk pools”) for people who cannot buy insurance in the individual market. Often, though, the premiums are expensive, so this is not ideal. If your state uses a high risk pool, fight for affordable premiums and subsidies for low-income people.
2. Limit insurers’ ability to look back into your medical history to determine whether you have a preexisting condition (ideally this “look back” period should be no more than six months prior to your purchasing the policy). Also limit the amount of time insurers are allowed to exclude coverage of that condition, and ban use of ‘exclusionary riders’ that deny coverage for a particular condition forever.
3. Fight for strict rules and state oversight about when insurers are allowed to revoke or limit policies that have already been issued.

Tell your state and federal legislators to stop insurance companies from using exclusionary practices to deny people coverage. Tell them we need quality, affordable health care for all!

¹ Grady, D., “After Cesareans, some see higher insurance cost,” The New York Times, June 1, 2008.

² Families USA, “Failing Grades: State Consumer Protections in the Individual Health Insurance Market,” June 2008, available at www.familiesusa.org

³ “How Private Health Insurance Works: A Primer, 2008 Update,” Kaiser Family Foundation.

⁴ See “Your Guide to HIPAA Protections,” on the website of Families USA at www.familiesusa.org

⁵ Lake Research Partners for the Herndon Alliance, 2007.

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FACT SHEET No. 2

Health care reform must actively work to end health disparities!

Making sure everyone has quality, affordable health coverage is an important first step in eliminating health disparities in the United States. People who have quality health coverage are much more likely to be able to obtain health care and to be in good health than those who are uninsured, or whose health coverage is limited.

But differences in people's health and access to health care persist even when they *do* have health coverage. Studies show these health disparities are often related to a person's gender, race, ethnicity, income, disabilities, sexual orientation or even place of residence. **These unfair and harmful differences amount to health injustice.** To achieve quality, affordable health for all, we must simultaneously expand coverage and reduce disparities.

What are health disparities? Health disparities are differences in access to health care and in actual health status among population groups. For example, African-American women have a 17 percent higher death rate from cancer than do white women.¹ The U.S. Department of Health and Human Services describes health disparities as gaps in the quality of health and health care across racial, ethnic and socioeconomic groups.²

Why do these disparities exist? The causes of disparities are complex. For example, the higher cancer death rate for African-American women may be explained in part by diagnosis at a later and more dangerous stage of cancer, and may also be related to less aggressive treatment of cancer.³ Some African-American women may also have higher risk factors for cancer because of poverty, poor diet, unhealthy living conditions, exposure to environmental toxins, lack of places to exercise and the stress caused by daily experiences with racism.

Wouldn't disparities be reduced by getting health coverage for everyone? Yes. Health coverage does open the door to routine checkups, preventive care and access to acute care. But even when everyone has health coverage, there *still* will be disparities. Studies have found that even when everyone in a population has the *same* health insurance coverage, some people still have more problems with obtaining health care and staying healthy than others do.

What additional steps do we need to take to eliminate health disparities? First, we must ensure that there are adequate numbers of health providers available to serve patients who have obtained coverage through health reform, particularly in low-income urban neighborhoods and rural areas. Second, health reform must promote the delivery of health care in a way that is culturally competent and respectful of patients from all backgrounds. Developing trust between physicians and patients can lead to more productive medical visits and help patients take a proactive role in improving their health care.⁴ Language translation services are essential to improve health provider communication with patients from immigrant populations. Special training may be necessary to improve health providers' ability to appropriately serve such populations as transgender persons. Alterations to medical offices and equipment may be necessary to make health care truly accessible for patients with disabilities.

Health reform must help prevent disease, as well as treat it. By promoting regular physical exercise and nutritional wellness, we can begin to address the epidemics of obesity and diabetes in many poor communities. Such efforts must be accompanied by steps to increase access to fresh fruits and vegetables in lower-income minority

neighborhoods and provide more recreational facilities. Increased cancer screenings will also help, but must be accompanied by steps to address pollution in urban areas. Knowledgeable patients are a crucial part of this equation. By making sure that language in health care brochures and in health insurance documents is clear and concise, we can begin to ensure that patients are not being left in the dark.

Examples of health disparities

Racial and Ethnic Disparities:

Non-Hispanic black women have the highest infant mortality rate in the U.S. – 13.60 per 1,000 live births compared to 5.66 per 1,000 births among non-Hispanic white women in 2004.⁵

The AIDS case rate for Latinas is more than 5 times that of white women.⁶

Women of color are more likely than white women to have difficulty communicating with their doctors,⁷ a barrier that prevents them from getting quality health care.

Vietnamese women in the U.S. have an incidence rate for cervical cancer that is five times higher than for white women.⁸ More than half of Vietnamese-American women have never had a pap smear, compared to 6% of all women.⁹

Gender Disparities:

A man's risk of dying from cardiovascular disease has decreased steadily since the 1980s; a woman's chances have not improved at all.¹⁰

Women are often excluded from clinical trials.¹¹ This is one reason why illnesses that primarily affect women are less well understood than those that affect men.¹²

Health care for female military veterans lags behind the care offered to male vets at many VA facilities. Female veterans aren't getting the same quality of outpatient care as men in about one-third of the VA's 139 facilities that offer it.¹³

Disparities Based on Disabilities:

Women with major mobility problems are 70 percent less likely to be asked about contraception, 40 percent less likely to receive a Pap smear and 30 percent less likely to have a mammogram.¹⁴

Women with disabilities are 20 percent less likely to receive breast-conserving surgery compared with women without disabilities.¹⁵

56% of women with disabilities who have given birth in hospitals, report that the hospital had failed to prepare for needed disability-specific accommodations.¹⁶

LGBT:

Lesbians are at an increased risk for certain cancers (lung, cervical, and breast cancer), due to inadequate risk assessment and screening by providers.¹⁷

Income:

Many racial and ethnic minorities and low-income people are less likely to receive recommended immunizations for influenza and pneumococcal pneumonia, the most common type of pneumonia.¹⁸

Since the Hyde Amendment, **between 18-35 percent** of Medicaid-eligible women who would have had an abortion if public funding had been available instead carried their unplanned pregnancy to term.

Push your legislators to take action and eliminate disparities in health care! For more resources and information about how to get involved, please see www.raisingwomensvoices.net!

¹http://www.cancer.org/docroot/MED/content/MED_2_1x_Report_Says_Half_a_Million_Cancer_Deaths_Have_Been_Averted_Since_Death_Rate_Drop.asp?sitearea=MED

² U.S. Department of Health and Human Services (HHS), *Healthy People 2010: National Health Promotion and Disease Prevention Objectives*, conference ed. in two vols (Washington, D.C., January 2000).

³ <http://cancercontrol.cancer.gov/womenofcolor/african.html>

⁴ <http://www.ama-assn.org/ama/pub/category/20.html>

⁵ <http://www.cdc.gov/nchs/PRESSROOM/07newsreleases/infantmortality.htm>

⁶ CDC, *HIV/AIDS Surveillance Report*, Vol. 18; 2008.

⁷ Eliminating racial and ethnic disparities in women's health care is focus of national symposium.

http://www.commonwealthfund.org/newsroom/newsroom_show.htm?doc_id=223590

⁸ Excellence centers to eliminate ethnic/racial disparities (EXCEED)

<http://www.medicalnewstoday.com/articles/70511.php>

⁹ Reproductive health care and Asian Pacific Islander women.

http://www.napawf.org/file/issues/factsheet_reprohealth_updated.pdf

¹⁰ American Heart Association. Women and cardiovascular disease: statistical fact sheet-populations. Available at: <http://www.americanheart.org/downloadable/heart/1045753419565FS10WM03.pdf>. Accessed October 10, 2003.

¹¹ Women's healthcare disparities and discrimination by Alyson Reed

http://findarticles.com/p/articles/mi_m0HSP/is_1_4/ai_66678569/pg_5

¹² Ten Priorities for Women's Health.

<http://www.arhp.org/files/journaleditorialoct2004.pdf>

¹³ http://www1.va.gov/health/docs/Hospital_Quality_Report.pdf

¹⁴ Women of Color with disabilities January 2006

<http://www.hhs.gov/od/topics/healthandhumanservices/nls0601hefner.html.html>

¹⁵ Disparities in Breast Cancer Treatment for women with disabilities.

http://bidmc.harvard.edu/tools/newsnow/pr_out.asp?pr_id=1424

¹⁶ http://www.dredf.org/healthcare/Access_Brief.pdf

¹⁷ www.lgbthealth.net

¹⁷ www.lgbthealth.net

¹⁸ <http://www.ahrq.gov/QUAL/nhdr03/nhdrsum03.htm#Disparities>

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FACT SHEET No. 3

Making Health Care Affordable for Women, Our Families and Our Communities

The skyrocketing cost of health care has affected everyone living in the United States, and the call for affordable health care is coming from individuals and communities from all income groups. Working families, large and small business owners, health care providers and health care institutions have all recognized the need to bring down the economic barriers that are preventing people from getting the health care they need.

Women are particularly hurt by the high cost of health care because of the cumulative effects of gender differences in health care needs and persistent economic discrimination. Squeezed at the intersection of these problems, women are having an increasingly difficult time getting health insurance that is affordable for themselves and their families to maintain and use. Here's why:

- **Women have less money and higher health costs than men**

Women earn less than men and are more likely to be poor. There was a gap of more than \$10,000 between men and women's annual earnings in 2004. At the same time, women need and use more health care services than men, which increases the cost burden of copayments and deductibles. The rising price of contraceptives, for example, is a cost often born by women alone. The health care cost imbalance is made worse in the 75 percent of states where insurance companies are allowed to charge higher rates to women.

- **Women are less likely than men to have a job that gives them health insurance and more likely to have to buy high-priced insurance that covers less**

The current U.S. health insurance system is an employer-based model that assumes most people will get health insurance through their jobs. But more and more people can't get insurance that way –because they are not employed or they work part-time in jobs that either don't provide a health insurance benefit or don't offer a health insurance plan that is affordable to a worker earning a part-time salary. Because more women than men work in part-time jobs and are unemployed, they have less access to employer-based health insurance.

Women who don't have insurance through a job can try to get dependent health insurance through a spouse, if they have one, or to buy individual health insurance policies. As insurance prices have gone up, however, employers have cut back on offering dependent coverage, limiting women's options still further. The last resort, individual health insurance policies, are expensive and they offer very low value for the high price. Without the leverage that employers can use to negotiate better terms for a group policy, women who try to buy health insurance individually usually have to pay higher rates for policies that have higher deductibles and more restrictions on use. They can even be denied individual coverage because of preexisting conditions, including breast cancer, pregnancy and having had a cesarean section delivery. (See *RWV fact sheet on preexisting conditions*.)

- **The affordability challenges in health care disproportionately affect women of color, immigrant women and women with disabilities**

The economic challenges that make health care unaffordable for women in general are more severe for women of color, immigrant women and women with disabilities, all of whom face higher rates of poverty and unemployment

than the general population. Immigrant women are also subject to legal and regulatory barriers that make it difficult for them to get regular, preventive health care in lower-cost settings and force them to delay needed care until a health crisis sends them to a hospital emergency room, where costs are higher. Women with disabilities have disproportionately greater and more specific health care needs that drive up their health care costs, make it harder for them to find affordable health care providers who can give them the care they need, and increase the likelihood that insurance companies will refuse to cover needed care.

- **Poverty, age and other social factors leave some women without affordable health insurance options**
Low-income women feel the stretch the most, but even in the middle class there are groups of women who fall between the cracks. Women in the 55–64 age group, for example, are too young to get health insurance through Medicare, but are at a stage of life when they may lose the dependent health insurance they have relied upon because of divorce or the death of a spouse.
- **Health care reform models that rely heavily on cost-sharing by consumers are likely to raise costs even higher for women and make existing gender inequities worse**
Politicians who oppose efforts to create quality, affordable health care for all often propose alternatives like Health Savings Accounts and other models that shift costs to consumers. These proposals disproportionately burden women with high health care costs because they do nothing to address existing economic inequities and burden women with even greater out-of-pocket health care costs. Research has shown, for example, that under this type of health care plan, women can be required to pay more than \$20,000 of the health care costs associated with having a baby. These models also create an economic incentive to use less health care, leading to cost barriers that make it less likely that women will get basic preventive care like mammograms and contraception.
- **Health care reform that meets women’s needs must be affordable and always available for women, our families and our communities**
To address the affordability challenges that women face, health care reform must ensure that health coverage – including not just premiums, but also any co-payments and deductibles – is affordable to buy and use. Individuals and families may be expected to contribute to the cost of health care, but such contributions should be consistent with their ability to pay. If we are going to continue to rely on an employer-based model of providing health insurance, we must create reliable ways for women who work part-time and those who are not employed to get affordable coverage.

Tell your state and federal legislators to health care must be affordable for women and their families. Tell them we need quality, affordable health care for all!

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