



What women want, and what we will get Do current health reform proposals meet our needs?

Raising Women's Voices has called for eight key improvements women want to see in health reform legislation. This fact sheet explains how those improvements are, or are not, addressed in the five Congressional bills issued as of October 15, 2009.

1. Make it fair. Don't charge women more than men. Don't let insurance companies refuse to cover people because they have diabetes, cancer, asthma or any other "pre-existing condition."



The short answer: All of the health reform bills pending in Congress would prohibit "gender rating," the practice of charging women more than men for the same insurance policy. The bills also would ban insurers from denying you coverage or charging you more because of a "pre-existing" condition, such as asthma, diabetes or breast cancer. This is great news for women, because insurers have denied some of us coverage on the basis of such "pre-existing conditions" as pregnancy, having had a previous c-section delivery and even having been a victim of domestic violence!

More details: The biggest improvement would come for those who are currently left out of the employer-provided health system and unable to buy health insurance on their own, even if they can afford it. All five Congressional committees have produced bills that envision creating health insurance "exchanges" (either state or national) through which uninsured individuals and families can purchase health coverage. In such an exchange, women and men would pay the same premiums for the same coverage, and insurance companies would have to accept everyone who applies, no matter what their health history is. Maternity care, often left out of individual policies now, would be included.



But, age discrimination would still be allowed: Insurance companies would continue to be able to charge older people more than younger people, a practice known as "age rating." This is a women's issue, as women are more likely than men to be without insurance when we're over 50, but not yet old enough (65) to qualify for Medicare. Older women experience this problem due to a variety of factors, including divorce, working for small businesses that don't offer insurance, or the retirement of an older spouse and resulting loss of family coverage. The version of the bill developed by the Senate Finance Committee is the worst in this area, allowing insurance companies to charge older individuals *four times as much* as younger folks. The bills from the other four committees allow a 2:1 age rating difference in premiums.

2. Health coverage should start at birth and end at death, with no interruptions. We shouldn't lose it when we change jobs, get divorced or move.



The short answer: The health reform proposals pending in the House and Senate will not guarantee you uninterrupted health coverage or provide absolute “portability” of your health insurance through all of life’s transitions. Instead, these proposals will provide a way for people to obtain new health insurance if they lose the policy they have by changing jobs, getting divorced or moving from one state to another.

Health insurance “exchanges” will be created – either nationally or by states, depending on the proposal – where people who have lost their insurance can compare and purchase new policies. Insurers participating in the exchanges will not be able to deny coverage to people with pre-existing conditions. Public subsidies will be available to help people who cannot afford the full premium cost of new policies.

More details: To guarantee truly portable health insurance coverage, we would have to get rid of the employer-based insurance system. One of the great advantages of a single-payer health reform model is that people don’t have to switch health insurance companies when they make a career change or go through a family transition. But when President Barack Obama promised that people who like the health insurance they have would be able to keep it, he committed himself to maintaining the structure of the current system, in which most people who are insured get their insurance as a benefit of being employed. So, people who have employer-based insurance will still face interruptions in coverage when we change jobs. In addition, the 25 % of women who are insured through a policy offered by a spouse’s employer might experience interruptions caused not just by a job-change, but also by the retirement or death of their spouses or by divorce.

3. Make it affordable. Use a sliding scale. Offer subsidies for those who can't pay very much.



The short answer: The health reform proposals pending in Congress would take **three** important steps toward making health insurance more affordable for women and our families. **First**, Congress would give public health insurance to more low-income families by qualifying them for Medicaid. **Second**, moderate-income families would get help buying insurance through a system of public subsidies based on a sliding scale according to family income. **Third**, health reform legislation would set limits on the annual amounts families are expected to spend on out-of-pocket health care costs, such as co-pays.

However, there are significant differences among the versions of health reform legislation that have emerged in the Senate and the House, and serious questions about whether health insurance would be truly affordable for moderate-income individuals and families under some versions. Four of the five Congressional bills include a public insurance option, which most experts believe would give consumers a cheaper alternative to private insurance. However, the powerful Senate Finance Committee did not include a public option in its bill.

More details: Here are the key elements that would be used to improve affordability of health coverage for American families, along with information comparing how the various Congressional proposals would treat these elements:

Medicaid expansion: The Senate Finance Committee bill would raise the eligibility ceiling for Medicaid to 133% of the federal poverty level, or \$24,352-a-year for a family of three. The House bills and the Senate Health, Education, Labor and Pensions (HELP) Committee bill are more generous, raising the eligibility ceiling up to 150% of the poverty level, or \$27,465 a year for a family of three.

Subsidies: All of the bills provide what are called “premium credits” to help individuals and families purchase insurance through the “exchanges” that would be created. The credits would be allotted on a sliding scale to individuals and families with incomes up to 400% of the poverty level. The House bills and the Senate HELP Committee bill would make health coverage more affordable than would the Senate Finance Committee bill, which would require families to spend a higher percentage of their incomes on health insurance premiums before they become eligible for public subsidies.

For example, a family of three earning \$27,465 a year would be expected to pay \$1,236 for premiums under the Senate Finance Committee bill, compared to only \$275 under the Senate HELP Committee bill. A family of three earning \$45,775 a year would be expected to pay \$4,349 a year for health insurance premiums under the Finance Committee bill, compared to \$2,563 under the HELP committee proposal.

Caps on out-of-pocket costs: All of the health reform bills set limits or caps on the amount of out-of-pocket costs, such as co-pays and deductibles, that individuals and families would be expected to pay each year. The goal is to protect more people against medical bankruptcy. Still, many people would still face significant out-of-pocket expenses if they are become seriously ill. The Senate HELP committee would set much a much lower annual cap on out-of-pocket expenses (\$2,320 a year) for a family of three earning \$27,465 annually than would Senate Finance (\$3,867). Families with higher, but still modest, incomes would do better under the Senate Finance Committee version than the HELP committee version. A family of three earning \$64,085 a year would be expected to pay up to \$7,733 a year in out-of-pocket health care costs under the Finance Committee version, compared to \$11,600 under Senate HELP.

Would combined maximum expense of health insurance premiums and out-of-pocket costs be affordable for your family?

Annual income family of 3	Senate HELP bill	Senate Finance bill
\$27,465	\$2,595	\$5,103
\$45,775	\$8,363	\$10,149
\$64,085	\$18,137	\$15,423
\$73,240	\$20,755	\$16,522

Source: Community Catalyst

4. Make it simple. Tell insurance companies to stop tricking us into buying policies that don't cover the care we need. There should be no hidden clauses or surprises.



The short answer: The creation of state or national insurance “exchanges” should help to take some of the mystery and danger out of buying health insurance on your own, if you do not receive employer-sponsored insurance. In theory, these exchanges would function like supermarkets for health insurance, allowing a potential buyer to more easily compare insurance plans, their costs and the benefits they provide. Exactly how this would be accomplished is not spelled out in the legislation.

Some of the most egregious hidden clauses or surprises that consumers have encountered in buying and using health insurance up until now, however, would be eliminated by provisions of all the Congressional health insurance bills that prohibit denials of coverage or charging of exorbitant premiums to people with pre-existing conditions.

5. Keep politics, politicians and ideology out of the decisions about which benefits should be included. This is health care, people!



The short answer: Two of the five Congressional committees voted to treat abortion services differently than any other type of health care, and it appears likely those provisions will end up in the final health care bill for political reasons. No public funding or public subsidies will be allowed for abortion services.

More details: The health reform bills passed by all five Congressional committees establish general categories of health services to be covered, setting up mechanisms for experts and stakeholders to make decisions about coverage of specific services based on medical evidence and standards of care. But two of the five bills – those passed by the House Energy and Commerce Committee and the Senate Finance Committee – make an exception to this rule, singling out abortion care to be treated differently. Pro-choice members of those committees agreed to this exception to gain the support necessary to defeat more sweeping abortion coverage restrictions, but it's still problematic.

The compromise language aims to preserve the status quo, leaving intact existing prohibitions on spending federal funds to cover abortion except in cases of rape, incest or threat to the life of the mother. This means that the most economically vulnerable women, those who receive health insurance through Medicaid, would continue to be denied access to basic health care. But the compromise would protect the ability of women who buy insurance through the exchange to buy a policy that covers abortion care, even if part of their premium is subsidized by public money. Under the compromise, insurance plans that participate in the exchange would be required to segregate public subsidy money from private premium dollars to ensure that subsidies won't be used to pay for abortion services.

6. Make it better. Give us the high quality care that this country is capable of delivering, instead of extra tests and unneeded services that feed the bottom line for drug companies or for-profit hospitals and medical systems at our expense. And fix the system so that poor people, people of color, people with disabilities and LGBT people get high quality care too.



The short answer: This is a pretty tall order, and certainly will not be completely solved by any health reform bill. Still, the bills pending in Congress do include some changes that are intended to make our health care better, at the same time as expanding health insurance coverage to many more Americans.

More details: Changes that have the potential to improve quality of care for everyone include federal research into what works (often called comparative effectiveness research); various programs to encourage more physicians to become primary care practitioners; changes in payment systems to cover other health professionals who play important roles in providing high quality care, such as midwives, nurse practitioners and social workers; programs to improve cultural and linguistic competency of health care workers and systems, and grants for demonstration projects designed to reduce the current disparities in health outcomes. Other things we like in various versions of the bills include federal standards for accessibility of medical equipment -- like adjustable exam tables and mammogram machines that work for women in wheelchairs (in the version passed by the Senate HELP committee) and requirements that federal health surveys stop pretending that GLBT folks don't exist and begin including them in reports on the health status of the population.

7. Cover everybody! Stop arguing about whether we should cover undocumented immigrants or force legal immigrants to wait five years to be eligible. If they are living here as our neighbors, we want them to be healthy. Fixing the immigration system is a separate issue.



The short answer: The bills produced by all five of the Congressional committees exclude undocumented immigrants from eligibility for subsidized health insurance and continue to make legal immigrants wait five years before they are eligible for Medicaid. Million of immigrants will be left without health coverage.

More details: All of the Congressional bills stipulate that people "not lawfully present" in the country may not receive public subsidies to purchase health insurance through the insurance exchanges. If we let immigrants contribute and buy affordable insurance premiums, hospitals and clinics will see fewer uninsured patients. Many immigrants pay the exact same taxes as U.S. citizens, but most legal immigrants are forbidden by Congress from using the Medicaid and Medicare programs paid for by these taxes. Health reform must be inclusive, and must not treat unfairly immigrant women and families.

Covering all the members of our communities, including immigrants, is a public health decision that is important for all of us. Our personal health and the health of our families can't be separated from the health of the entire community. If we allow everyone to pay into the system and get the health care they need, we will all benefit from a healthier community.

8. This should be a wellness system, not a sickness system. Sure, we want to have medical care when we get sick, but better preventive care and stronger public health measures in our own communities can help us stay healthy.



The short answer: Health reform would take some initial steps towards shifting our health system from treating illness to promoting wellness. One important feature of the health reform bills pending in Congress is that co-pays would be eliminated for certain health screenings and preventive care. However, different versions on the health reform bills address separate groups of people and have different requirements for what care is covered. The Senate HELP committee bill also includes important investments in training more public health and primary care workers.

More details: Senate HELP would require health plans to cover preventive measures recommended by the U.S. Preventive Services Task Force (USPSTF). This requirement would apply to those people enrolled in any public option that is included in health reform, as well as those people in private plans. Such coverage would include regular mammography exams for women over 40, tobacco cessation counseling, depression screening for adults and adolescents, osteoporosis screening for women over 65, genetic counseling for women with a family history of breast cancer (BRCA gene), various STI screening and support for mothers who breastfeed.

The Senate Finance provisions waive co-pays for preventive care and screenings for people enrolled in Medicare and Medicaid. Instead of specifying use of the USPSTF's list of recommended preventive services, Senate Finance would look to recommendations of the Secretary of Health and Human Services and other groups. Senate Finance has also put aside \$100 million to establish healthy lifestyle programs for Medicare/Medicaid recipients. These programs would address such health problems as high blood pressure, high cholesterol and diabetes. Incentives would be provided for patients who complete the program and those who adopt these health behaviors. Additionally, the bill sets aside \$25 million to establish a childhood obesity prevention program that promotes public awareness and provides obesity screening and counseling for those enrolled in Medicaid.

The Senate HELP bill includes full funding for the Prevention and Public Health Investment Fund and other important provisions, such as grants and training programs to produce more public health workers, nurses and dentists for rural areas.