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 combined House bill which, passed on November 7, and the two Senate bills.

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 the bills would create 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. The new House combined bill also would encourage employers to offer domestic partner coverage by giving employers the same tax benefits they get for offering dependent coverage to married people. That's more fair!

Unfortunately, not all the bills extend these protections equally to people who get insurance through their jobs. The Senate Finance Committee bill would limit many of the improvements – including the ban on gender rating – to insurance policies negotiated by small employers (currently defined as no larger than 50). This means that it would still be legal for insurance companies to charge higher rates to larger companies that employ a lot of women, like home health care providers, and those higher prices will be likely to hold down salaries and other compensation women might get from their jobs. The Finance Committee bill also would phase the protections into effect slowly over time, unlike the Senate HELP Committee bill which has no phase-in.

Even worse, 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. We understand the combined Senate bill may use a 3:1 ratio, but that bill still has not been released.

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. Young adults also would be able to stay on their parents’ health insurance policies until their 27th birthdays, under the House bill, an important option for young people who graduate from high school or college and find entry-level jobs that do not provide health coverage.

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 policies 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 **five** 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 making them

eligible 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. **Fourth,** older women would benefit from several provisions for early retirees and for those on Medicare, including closing of the Medicare Part D prescription drug "donut hole." **Fifth,** there would be a government-sponsored "public option" health plan that could offer consumers cheaper coverage than in private plans.

However, there are significant differences among the versions of health reform legislation that have emerged, and serious questions about whether health insurance would be truly affordable for moderate-income individuals and families under some versions. The House combined bill and the Senate HELP Committee's bill include a public insurance option, which most experts believe would give consumers a cheaper alternative to private insurance. The Senate Finance Committee did not include a public option in its bill. Senate Majority Leader Harry Reid has announced, however, that he intends to include a public option in the merged Senate bill. He has said that the Senate public option will allow states that don't want to offer this choice to opt out.

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 various 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 combined bill and the Senate 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 ($33,100 per year for a family of four).

Subsidies: All of the bills provide subsidies or tax 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 (about $88,000 a year for a family of four) starting in 2013. The House and the Senate HELP Committee bills 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.

A comparison of the two Senate bills illustrates the differences between them. 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, under the Senate Finance Committee proposal, many people would still face significant out-of-pocket expenses if they 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 under the Senate proposals 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

The new combined House bill has lower annual out-of-pocket cost caps, ranging from $500 for an individual/$1,000 for a family at the lowest end (under 150% poverty) up to $5,000 for an individual and $10,000 for a family at the level of 350 to 400% of poverty.

Medicare Prescription Drug Plan: The House bill would make prescription drugs more affordable for older women on Medicare by gradually closing the Medicare Part D “donut hole,” and requiring the government to negotiate with drug manufacturers for lower prices. It reduces the donut hole by $500 and institutes a 50 percent discount for brand-name drugs when an enrollee is in the donut hole and has to pay for her own medicines, effective in 2010. In 2019, it eliminates the donut hole entirely.

Insurance Protections for Retirees: The combined House bill includes two new provisions that would help retirees. First, early retirees who are not yet eligible for Medicare would be helped by a $10 billion fund to finance a “reinsurance” program to hold down the costs of expensive health claims for those employers that provide health benefits for retirees ages 55-64. Second, employers would be prohibited from reducing retirees’ health benefits after they have retired, unless the reduction is also made for current employees.

Public Option: The new House bill adopts a weaker version of a public option than what progressive health reform advocates had hoped to see. Instead of tying reimbursement rates for providers to the Medicare schedule plus 5 percent (a formula known as the “robust” public option), this bill would require the federal government to negotiate with providers on reimbursement rates, the same way that private insurance plans do. This means the public option will not be as cheap as it could be, at least at first, because there will not be enough enrollees in the public option initially to give it the necessary market power to demand significant discounts from providers. While we are pleased the public option is included, we are concerned that House leaders passed up the chance to make sure it will provide a significantly cheaper choice. If Senator Majority Leader Reid follows through on his announced intentions, the merged Senate bill will include a public option that also adopts this approach, and further would allow states to opt out of it, so consumers in some states would not get the advantage of a public option.

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" will 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. These exchanges are intended to function like supermarkets for health insurance, allowing a potential buyer to more easily compare insurance plans, their costs and the benefits they provide. Each plan would have to include a standard set of benefits.

Some of the most egregious hidden clauses or surprises that consumers now encounter in buying and using health insurance would be eliminated. All the bills, for example, prohibit insurers from setting lifetime caps on coverage or charging exorbitant premiums for coverage that includes specific services which people with a history of illness or with chronic conditions may need.

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

The short answer: The short answer: House Bill HR 3692 was amended at the 11th hour to include an attack on coverage for reproductive health care. Acting under pressure from anti-choice Democrats and the U.S. Conference of Catholic Bishops, House leadership permitted a vote that attached to health reform a sweeping abortion ban on insurance policies offered through the health exchange that will effectively take coverage away from women who have it now. If enacted, this language will exclude abortion coverage not only from federally-financed Medicaid coverage, but also from the public plan option and from private insurance plans participating in the exchange that accept any public subsidy money. (Plans that do not accept such subsidies would be cutting themselves off from the vast majority of the potential market and may not be economically viable.)

More details: Instead of presenting an abortion-neutral bill that treated reproductive health services like other health services, House leadership had included provisions in its health reform bill that prohibited the use of federal funds to pay for abortions except in cases of rape, incest or threat to the life of the mother. That compromise was based on the Capps amendment, adopted earlier by the House Energy and Commerce Committee, and would have maintained the status quo on federal funding of abortion. But insurance plans offered through the exchange would still have been able to cover abortion as long as any public subsidies that women used to purchase insurance were segregated from women's private premium dollars and only private funds were used to pay for abortion services. This compromise was also included in the Senate Finance Committee health reform bill.

Not satisfied with the compromise, anti-choice lawmakers and the U.S. Conference of Catholic Bishops threatened to scuttle passage of HR 3692 unless their demands for more restrictions on abortion coverage were met. To gain the support of antichoice Democrats whose votes were needed to pass the health reform bill, the leadership allowed Representative Bart Stupak of Michigan to offer an amendment which imposed

the new restrictions, and the House accepted it with more than 60 Democrats and all of the Republicans voting in favor of the Stupak restrictions. If the Senate includes similar restrictions when it votes on a bill and if those restrictions are included in the final legislation, the millions of women who will get insurance through the new exchange and who currently have insurance policies that cover abortion will likely lose that coverage.

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: All the bills exclude undocumented immigrants from eligibility for subsidized health insurance and continue to make legal immigrants wait five years before they are eligible for Medicaid.. According to the Associated Press, the new House bill would cover about 96 percent of legal residents under age 65 — compared with 83 percent now. About one-third of the remaining 18 million non-elderly people left uninsured would be undocumented immigrants.

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. . The Senate HELP committee bill and the House bill include important investments in training more public health and primary care workers. Another important feature included in some form in all the bills is a provision eliminating co-pays for certain health screenings and preventive care. However, only the Senate HELP bill ensures that family planning would be included on the list of preventive services that are exempt from co-pays

More details: Both the Senate HELP bill and the House bill 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.

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