Comprehensive Health Care Reform

An Essential Prescription for Women

A Report by the Joint Economic Committee
Representative Carolyn B. Maloney, Chair
Senator Charles E. Schumer, Vice Chair
August 6, 2009

Executive Summary

The status-quo health insurance system is serving women poorly. An estimated 64 million women lack adequate health insurance.[1] Over half of all medical bankruptcies are filed by female-headed households.[2] For too many women and their families today, quality, affordable health care is out of reach.

Women are more vulnerable to high health care costs than men. Several factors explain why. First, women's health needs differ from men's, so women are obliged to interact more regularly with the health care system – regardless of whether they have adequate insurance coverage or not. Second, women are more likely to be economically vulnerable and therefore face devastating consequences when faced with a mounting pile of medical bills. The inability of the current system to adequately serve women's health care needs has come at great expense. One recent study estimates that women's chronic disease conditions cost hundreds of billions of dollars.[3]

The following brief provides an overview of the basic facts regarding women's insurance coverage, and the consequences of our broken health insurance system on women's health – both physical and financial. Specifically:

- **Over one million women have lost their health insurance due to a spouse's job loss during the current economic downturn.** Women have lost 1.6 million jobs since the recession began in December 2007, and many of those women saw their health insurance benefits disappear along with their paychecks.[4] Second, women whose spouses lose their jobs are also vulnerable to losing their health benefits, because so many women receive coverage through a spouse's job-based plan. The Joint Economic Committee estimates that *over 1.4 million women* have lost health insurance benefits because of the contraction in the labor market since December 2007. 71 percent (1,001,913) lost their insurance due to a spouse's job loss. 29 percent (414,964) of those women lost their insurance due to their own job loss.

- **As a consequence of single mothers' job loss, the Joint Economic Committee estimates that *at least 121,000 children* have lost health insurance coverage.[5]** The weak job market has been rough on single mothers; the number of unemployed female heads of household has increased 53 percent over the past twelve months.[6] For many of these women, the loss of a job means not only a disappearing paycheck, but also the disappearance of employer-sponsored health insurance coverage for their families.

- **Women between the ages of 55 and 64 are particularly vulnerable to losing their health insurance benefits because of their husbands' transition from employer-sponsored coverage to Medicare**. One recent study concludes that a husband's transition from employer-sponsored coverage to Medicare at age 65 can be problematic for his younger wife. Many of these wives depended on their spouse's employer-based coverage and are not yet age-eligible for Medicare. As a result, 75 percent of these women reported delaying filling prescriptions or taking fewer medications than prescribed because of cost.[7]

- **Younger women are particularly vulnerable to lacking adequate health insurance coverage.** Over one-quarter (28 percent) of all young women (ages 19-24) do not have health insurance coverage. The weak job market has hit young workers particularly hard, with the unemployment rate amongst young women at 15.7 percent in June 2009, the highest in a quarter century and substantially higher than the national unemployment rate of 9.5 percent.[8] The dismal job market means that young women are less likely than ever to have access to job-based coverage, and many women who once received coverage through a parent's health insurance plan have seen this coverage evaporate with their parents' jobs.

- **41 percent of all low-income women lack health insurance coverage**. Because of wide variability in state Medicaid eligibility rules, millions of American women fall through the safety net every day. The devastating impact of the recession on state budgets has forced some states to further tighten Medicaid eligibility rules at precisely the time when need is growing fastest.

- **The health consequences of inadequate coverage are more severe for women than for men**. Women are more likely than men to run into problems receiving adequate medical care. Over a quarter (27 percent) of women had health problems requiring medical attention but were not able to see a doctor, compared to 21 percent of men. Similarly, nearly a quarter (22 percent) of women reported that they were unable to fill a needed prescription, as compared to 15 percent of men.

- **While the financial burden of inadequate health insurance coverage weighs heavily on all Americans, uninsured and under-insured women suffer more severe economic consequences than do men.** Women are more likely than men to deplete their savings accounts in order to pay medical bills. One-third of under-insured women deplete their savings to pay medical bills, as compared to a quarter of under-insured men. The disparity is comparable amongst the uninsured (34 percent of uninsured women as compared to 29 percent of uninsured men).

The comprehensive health care reform proposals offered by the Obama Administration and currently taking shape under the leadership of Democrats in the House and Senate include numerous provisions that are critical to providing quality, affordable health care for *all* Americans, both women and men. Many of these solutions are a key part of the prescription for easing the burden on America's women, for whom the status quo health care system is a failure.

Comprehensive Health Care Reform: An Essential Prescription for Women

The status-quo health insurance system poorly serves women. An estimated 64 million women lack adequate health insurance.[9] Over half of all medical bankruptcies are filed by female-headed households.[10] For too many women and their families today, quality, affordable health care is out of reach.

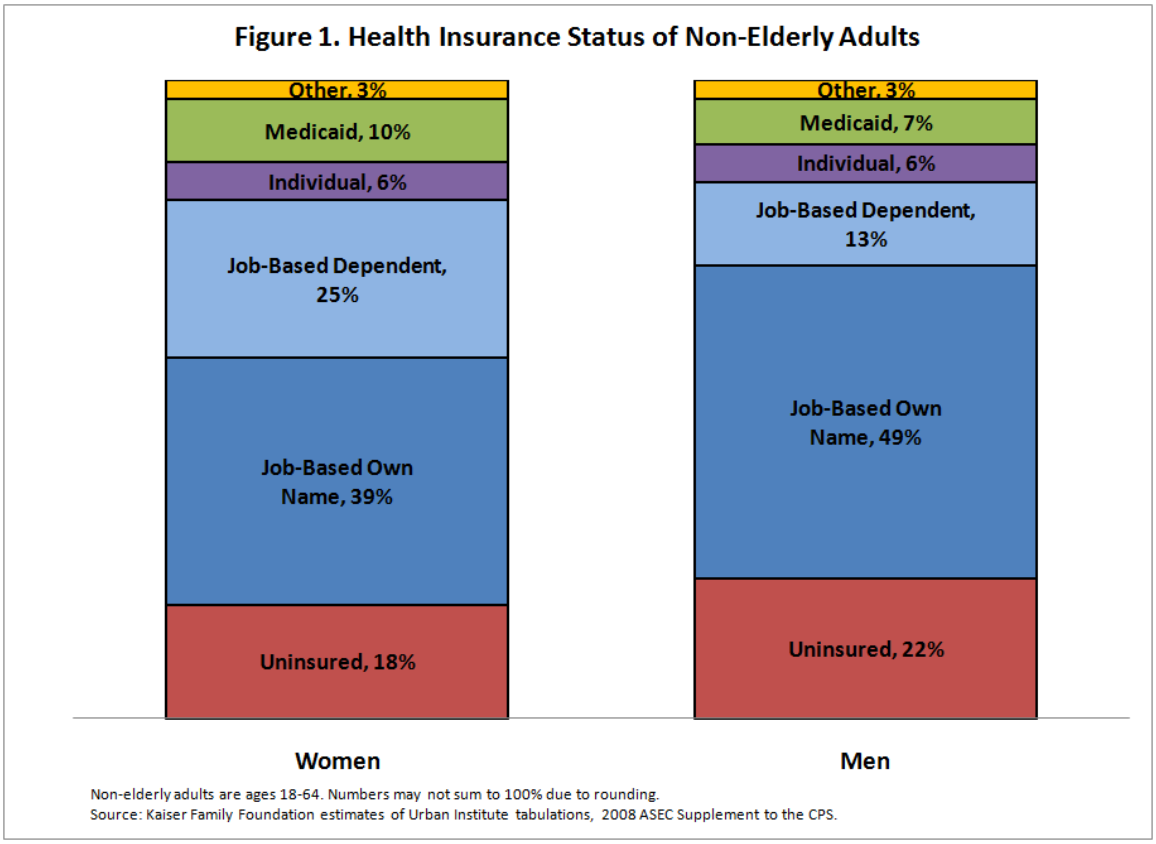
Women are more vulnerable to high health care costs than men. Several factors explain why. First, women's health needs differ from men's, so women are obliged to interact more regularly with the health care system – regardless of whether they have adequate insurance coverage or not. Women's reproductive health concerns, including pregnancy and childbirth, contraception, and the consequences of sexually-transmitted diseases, require more contact with medical providers.[11] Women are more likely than men to have one or more chronic diseases, including diabetes, asthma, hypertension, all of which require ongoing coordinated care.[12] Second, women are more likely to be economically vulnerable and therefore face devastating consequences when faced with a mounting pile of medical bills. Women comprise more than half of America's poor, and millions of working women continue to earn less than their male counterparts.[13] Regardless of marital status, women are more likely to be responsible for their children's health and well-being.[14]

The inability of the current system to adequately serve women's health care needs has come at great expense. One recent study estimates that women's chronic disease conditions cost hundreds of billions of dollars.[15] The direct costs of women's cardiovascular disease, which impacts 43 million American women, are estimated at $162 billion annually. The direct medical costs of diabetes on women totals over $58 billion. The direct medical costs of osteoporosis, which impacts 8 million women, are estimated at nearly $14 billion annually. The direct medical costs of breast cancer are estimated at $9 billion.

The following brief provides an overview of the basic facts regarding women's insurance coverage, and the consequences of our broken health insurance system on women's health – both physical and financial.

Women are no more likely than men to be uninsured, but the sources of women's health insurance policies are quite different from men's. As a result, women are especially vulnerable to losing their health insurance coverage.

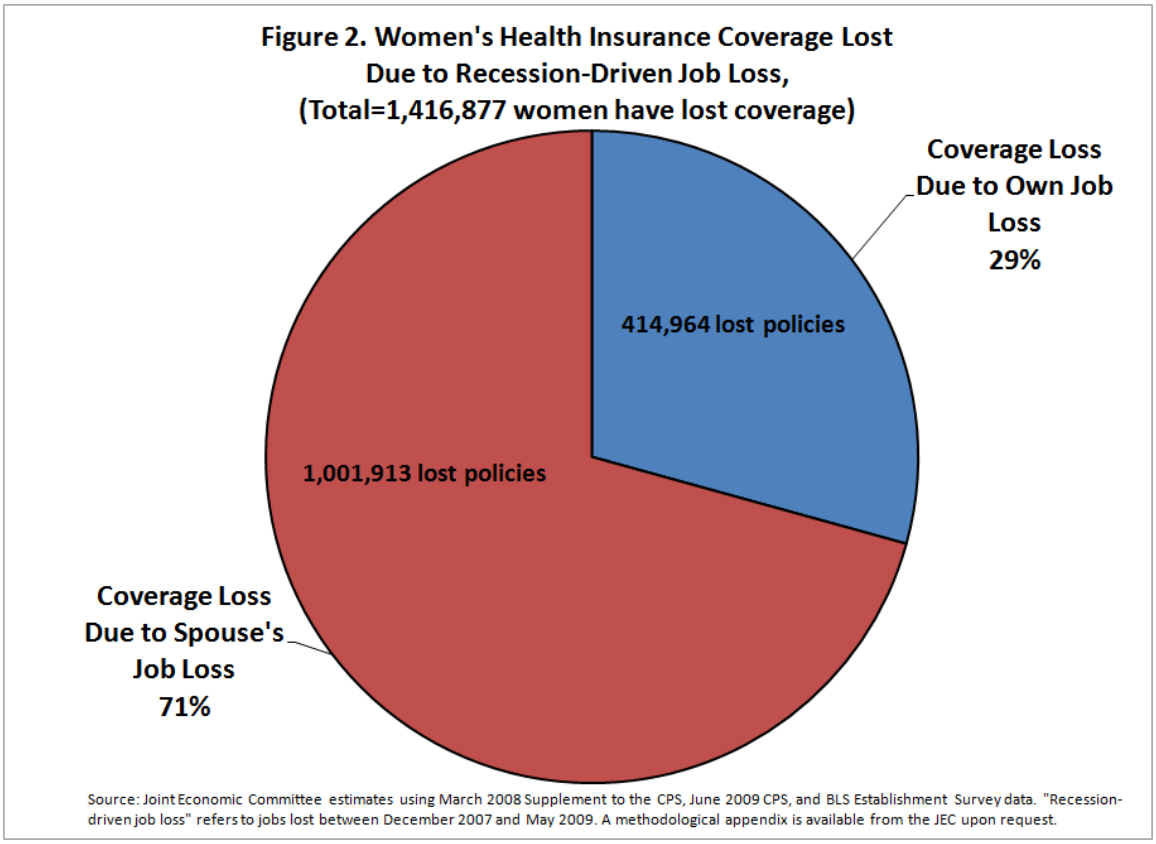
Because women are less likely than men to be employed full-time, they are less likely to be eligible for employer-provided health benefits. 26 percent of employed women work part-time, and are therefore excluded from their employers' health insurance benefit plans. In contrast, just 13 percent of working men are part-time employees.[16]



Women are nearly twice as likely as men to depend on a family member (typically a spouse) for health insurance benefits. 25 percent of non-elderly women receive health insurance coverage as a dependent on a family members' job-based health insurance plan, as compared to just 13 percent of men. Women are particularly vulnerable to losing health insurance coverage when they are dependent on someone else for their benefits.

First, the weak job market means that a woman is vulnerable to losing employer-based coverage because of loss of her own job or her spouse's job loss. Women have lost 1.6 million jobs since the recession began in December 2007, and many of those women saw their health insurance benefits disappear along with their paychecks.[17] Many more women have lost their employer-provided health insurance benefits as businesses have cut back on employees' hours. Over one million women who usually work full-time are currently working part-time because full-time work is not available, a 65 percent increase since the recession began in December 2007. Many of these women are no longer eligible for employer-sponsored coverage.[18] As noted above, women's health insurance coverage is impacted not only by their own employment, but also by their spouse's employment. Women whose spouses lose their jobs are also vulnerable to losing their health benefits, because so many women receive coverage through their spouses' job-based plans. Men have lost 4.5 million jobs since the recession began, resulting in millions more wives losing their health insurance coverage and joining the ranks of the unemployed. The combination of women's job loss and their spouse's job loss means that women are doubly vulnerable to losing their health insurance coverage in today's weak economy.

Using these job loss statistics and the share of men and women receiving health insurance benefits through employer-sponsored plans, we estimate that *over 1.4 million women* have lost health insurance benefits because of the contraction in the labor market since December 2007. 29 percent (414,964) of those women lost their insurance due to their own job loss. 71 percent (1,001,913) lost their insurance due to a spouse's job loss. In contrast, 2.7 million men have lost health benefits due to job loss since the recession began. Nearly all (97 percent) of those losses are due to men's own job loss.[19]



Health insurance losses due to the economic contraction are likely substantially larger than the Joint Economic Committee's estimates of job-loss related health insurance losses. The rising cost of providing employees with health insurance coverage combined with the economic slowdown means that some employers have dropped health insurance benefits for their employees. Therefore, many Americans who remain employed may no longer have health insurance coverage.[20]

Second, women between the ages of 55 and 64 are particularly vulnerable to losing their health insurance benefits because of their husbands' transition from employer-sponsored coverage to Medicare. One recent study concludes that a husband's transition from employer-sponsored coverage to Medicare at age 65 can be problematic for his younger wife. Many of these wives depended on their spouse's employer-based coverage and are not yet age-eligible for Medicare. As a result, many of these women experience disruptions in medical care. For example, 75 percent of women who experienced an insurance disruption due to husbands' transitions to Medicare reported delaying filling prescriptions or taking fewer medications than prescribed due to

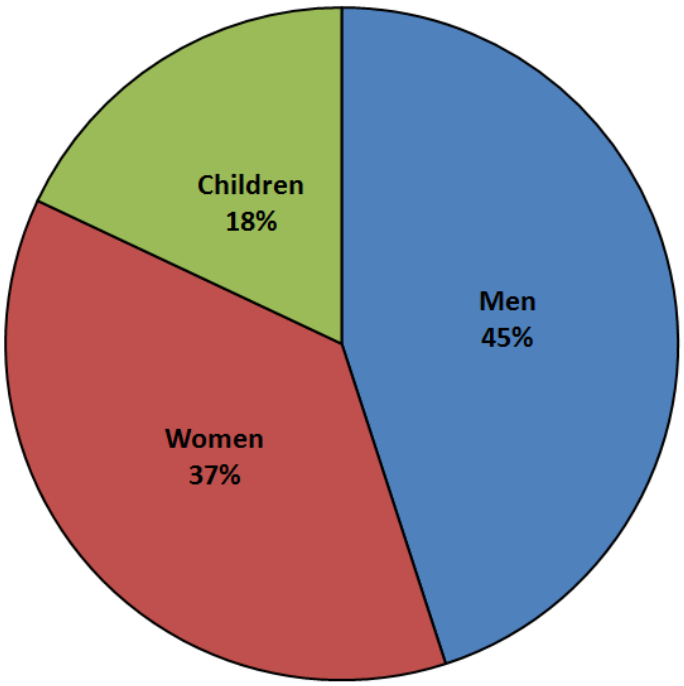
cost. These numbers were substantially smaller for similar women who did not experience this insurance disruption.[21]

Women without access to employer-based health insurance benefits – either from their own job or a family members' job – are left to find insurance on their own. 10 percent of all women are insured through Medicaid. 6 percent purchase insurance on the individual market, which can come at an enormous cost. For instance, in many states, a 25 year-old woman purchasing health insurance on the individual market pays 45 percent more in monthly premiums for the exact same plan purchased by a 25 year-old male.[22]

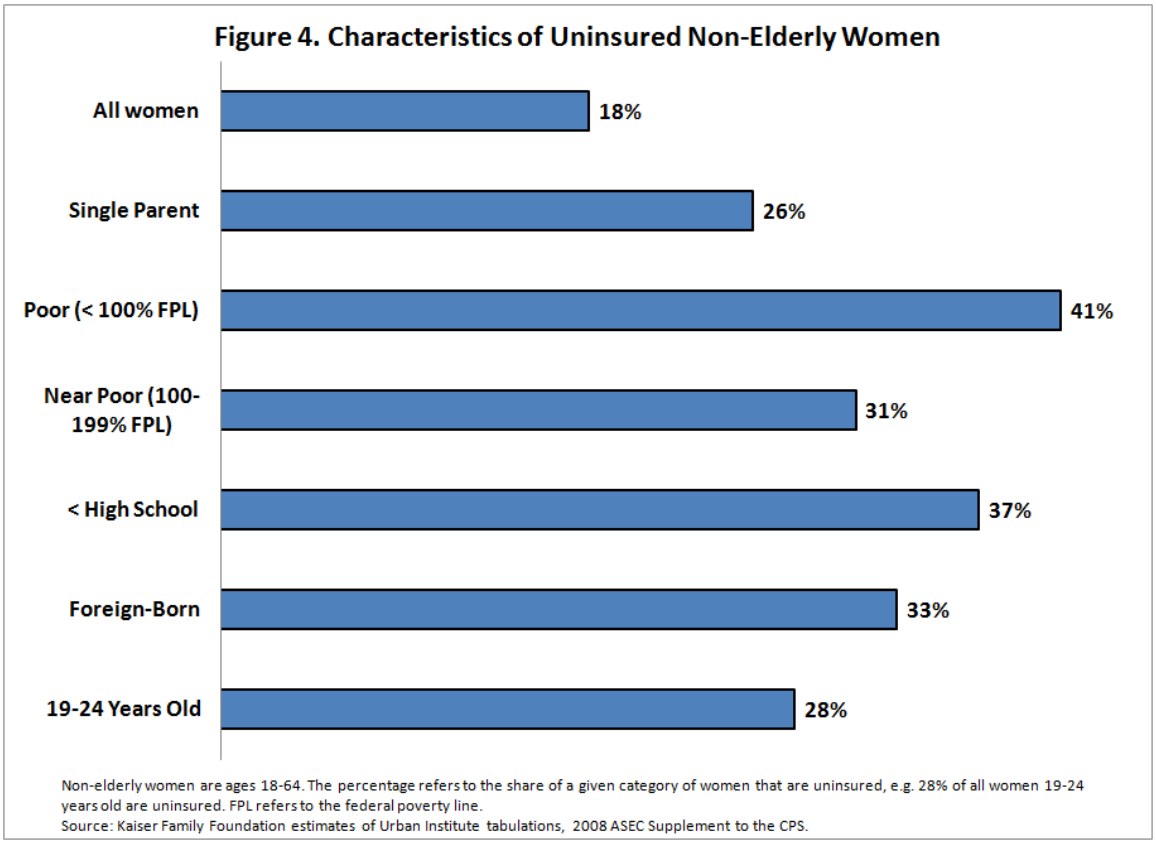
Adult women comprise 37 percent of the uninsured. Certain groups of women are far more likely to be uninsured or under-insured than others. While just 18 percent of all women are uninsured, much larger shares of certain groups of women are left without coverage today.

Over a quarter (26 percent) of all single mothers do not have health insurance coverage. 41 percent of all children without health insurance live in single-parent families, the vast majority of which are headed by a working single mother.[23] The weak job market has been rough on single mothers; the number of unemployed female heads of household has increased 53 percent over the past twelve months.[24] For many of these women, the loss of a job means not only a disappearing paycheck, but also the disappearance of employer-sponsored health insurance coverage.

Figure 3. Distribution of the Uninsured, (Total=45.7 million)



Children are under 18 years old.
Source: Kaiser Family Foundation estimates of Urban Institute tabulations, 2008 ASEC Supplement to the CPS.

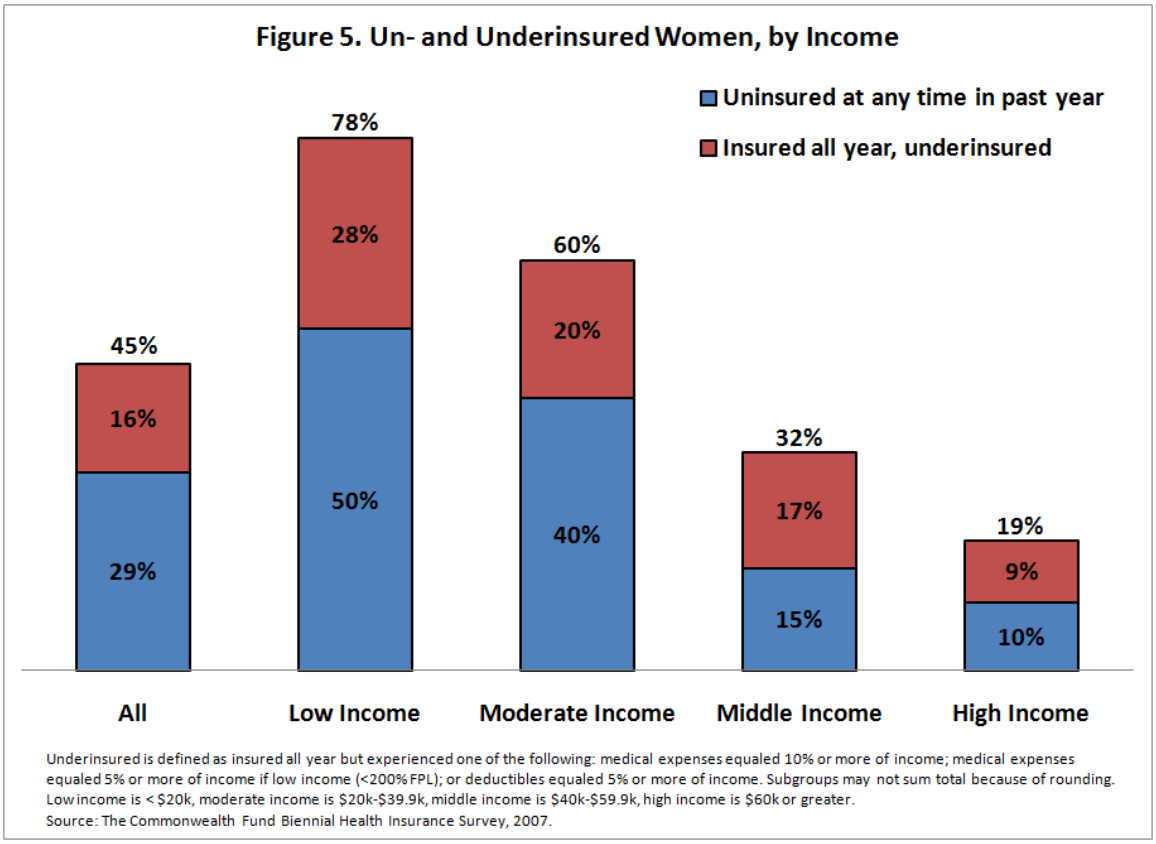


As a consequence of single mothers' job loss, the Joint Economic Committee estimates that *at least 121,000 children* have lost health insurance coverage that they received through their mother's employer-based plans.[25] The recovery package included subsidies to make COBRA coverage more affordable, allowing some of these families to purchase an extension of their existing health insurance coverage for a limited time. But COBRA coverage remains prohibitively expensive for many Americans, particularly working single parents, and many women work for businesses that are too small to be bound by COBRA regulations.[26]

Over one-quarter (28 percent) of all young women (ages 19-24) do not have health insurance coverage. The weak job market has hit young workers particularly hard, with the unemployment rate amongst young women at 15.7 percent in June 2009, the highest in a quarter century and substantially higher than the national unemployment rate of 9.5 percent.[27] The dismal job market means that young women are less likely than ever to have access to job-based coverage, and many women who once received coverage through a parent's health insurance plan have seen this coverage evaporate with their parents' jobs. Moreover, over half (60 percent) of employer-sponsored health plans do not cover dependents after age 19 if they are not enrolled in school. The vast majority of students covered through their parents' employer-based policies lose their health insurance benefits upon college graduation.[28]

Millions of poor and near-poor women lack health insurance. 41 percent of women living at or below the federal poverty line ($22,050 for a family of four in 2009) do not have health insurance coverage. Nearly a third (31 percent) of near-poor women living between 100-199 percent of the federal poverty line lack coverage. Medicaid eligibility rules vary substantially across

states. The safety net program covers just 45 percent of low-income Americans, leaving millions of low-income women without access to affordable health insurance coverage.[29] Facing serious budgetary pressures due to the recession, some states have further pared back Medicaid eligibility and/or benefits at precisely the time when increasing numbers of families desperately need access to public benefits.[30]



While millions of women lack access to health insurance, millions more women are "underinsured," or covered by health insurance benefits that leave them vulnerable to significant financial hardship. Under an expanded definition of lack of access to health insurance coverage that includes both the uninsured and underinsured, the percentage of women lacking adequate health coverage rises to 45 percent. Over three-quarters (78 percent) of low-income women lack adequate coverage. 60 percent of moderate-income women lack adequate coverage. Even amongst relatively well-off Americans, access to adequate coverage remains tenuous.[31]

Health insurance coverage also varies substantially by race. Minority women, especially Hispanics and Native Americans, have the greatest rates of non-insurance – 37 percent of Hispanic women lack health coverage, as do 31 percent of Native American women.

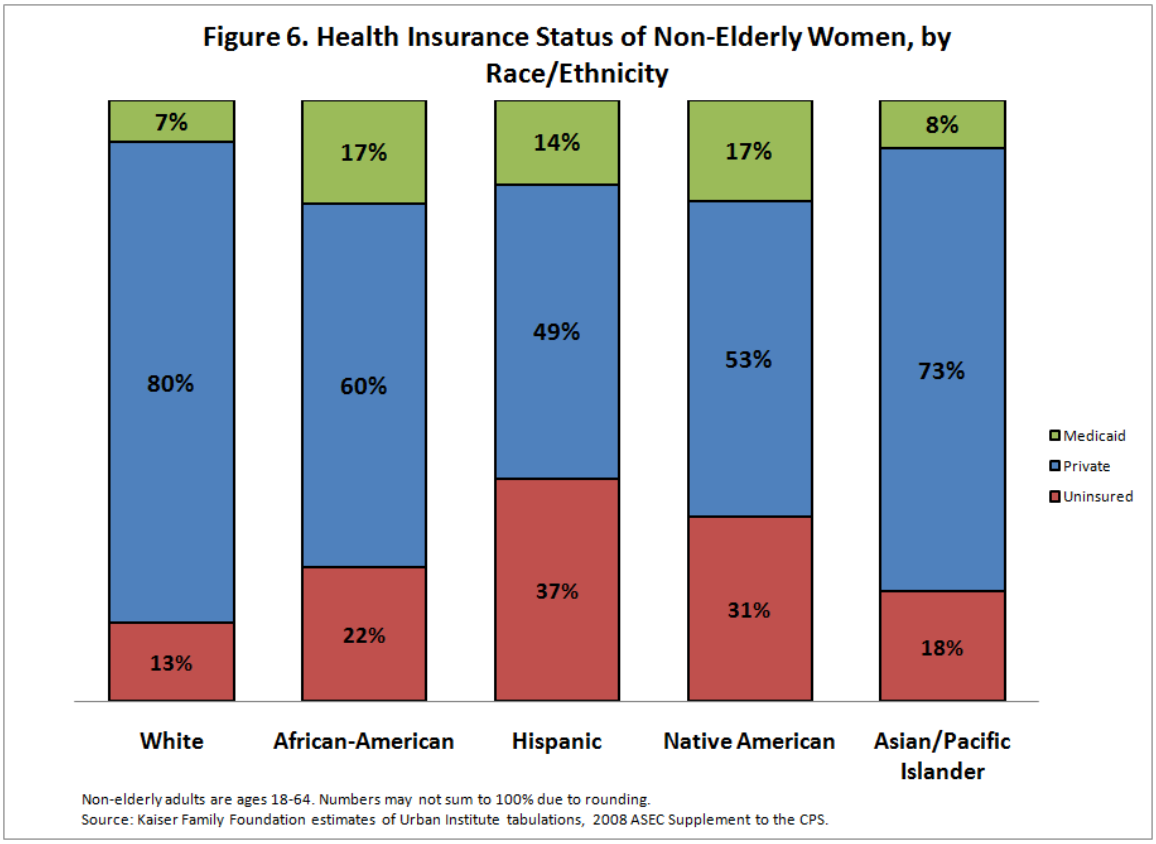


Figure 6. Health Insurance Status of Non-Elderly Women, by Race/Ethnicity
7%
80%
13%
17%
60%
22%
14%
49%
37%
17%
53%
31%
8%
73%
18%
Medicaid
Private
Uninsured
White
African-American
Hispanic
Native American
Asian/Pacific Islander
Non-elderly adults are ages 18-64. Numbers may not sum to 100% due to rounding.
Source: Kaiser Family Foundation estimates of Urban Institute tabulations, 2008 ASEC Supplement to the CPS.

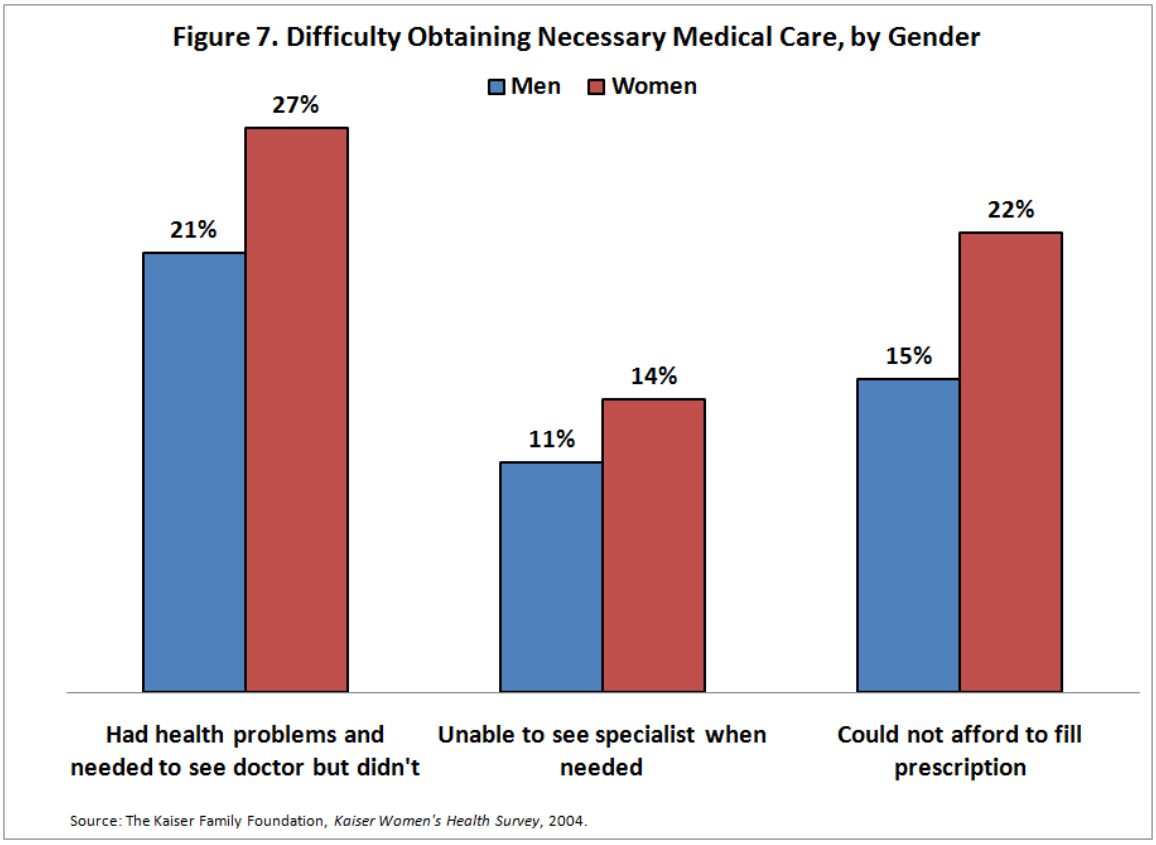
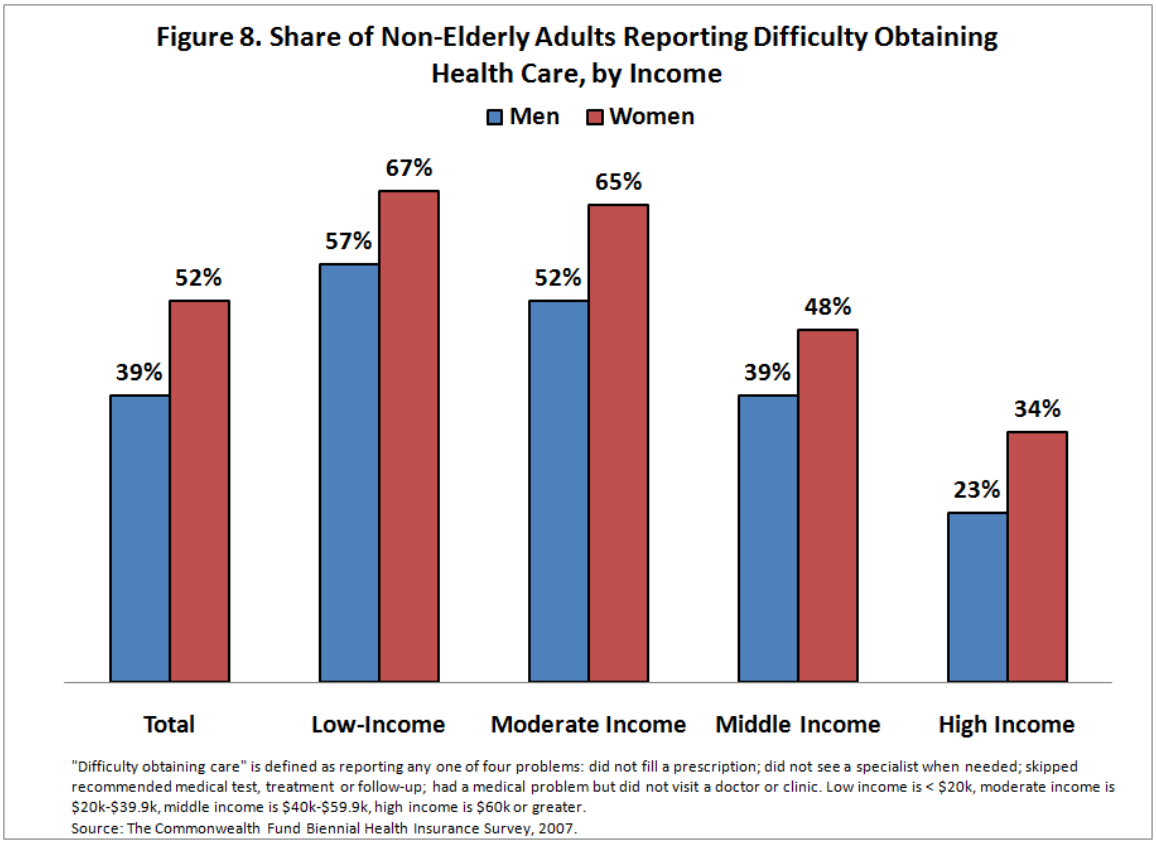


Figure 7. Difficulty Obtaining Necessary Medical Care, by Gender
Men
Women
21%
27%
11%
14%
15%
22%
Had health problems and needed to see doctor but didn't
Unable to see specialist when needed
Could not afford to fill prescription
Source: The Kaiser Family Foundation, Kaiser Women's Health Survey, 2004.



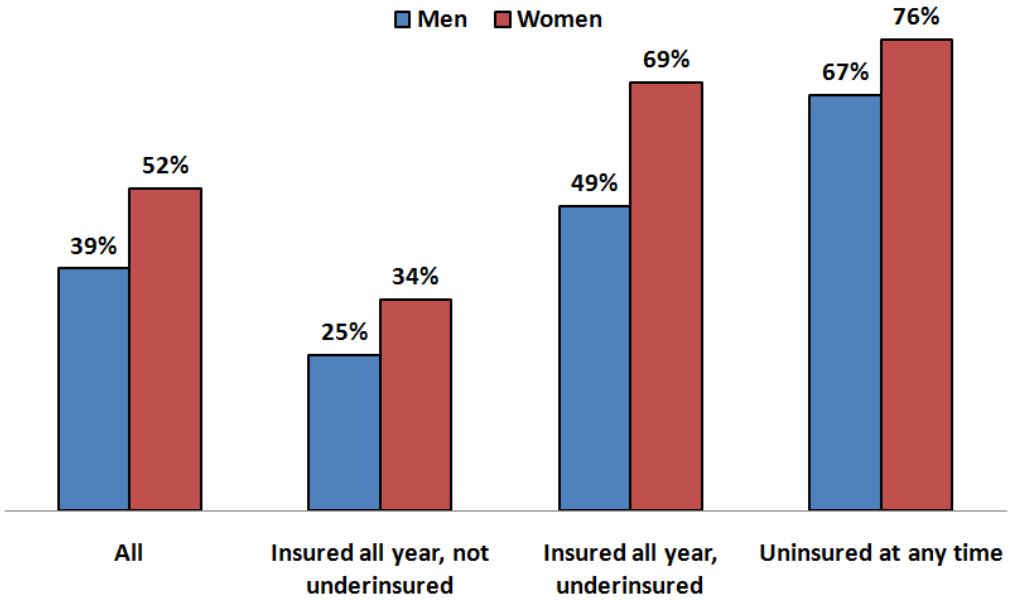
Women are more likely than men to report problems with access to medical care.

Women are more likely than men to run into problems receiving adequate medical care. Over a quarter (27 percent) of women had health problems requiring medical attention but were not able to see a doctor, compared to 21 percent of men. Similarly, nearly a quarter (22 percent) of women reported that they were unable to fill a needed prescription, as compared to 15 percent of men.

While the percent of men and women reporting difficulty obtaining needed care is inversely related to income, the gender gap in obtaining care is relatively constant regardless of income.[32] While 39 percent of all men reported difficulty, over half (52 percent) of all women reported trouble obtaining needed medical care. Amongst the lowest-income individuals, 57 percent of men report difficult as compared to 67 percent of women – a 10 percentage point gap. Amongst higher income individuals (those with incomes of $60,000 or more), the percentage of both men and women reporting difficulty obtaining needed care is lower, but the gender gap remains, at about 11 percentage points.

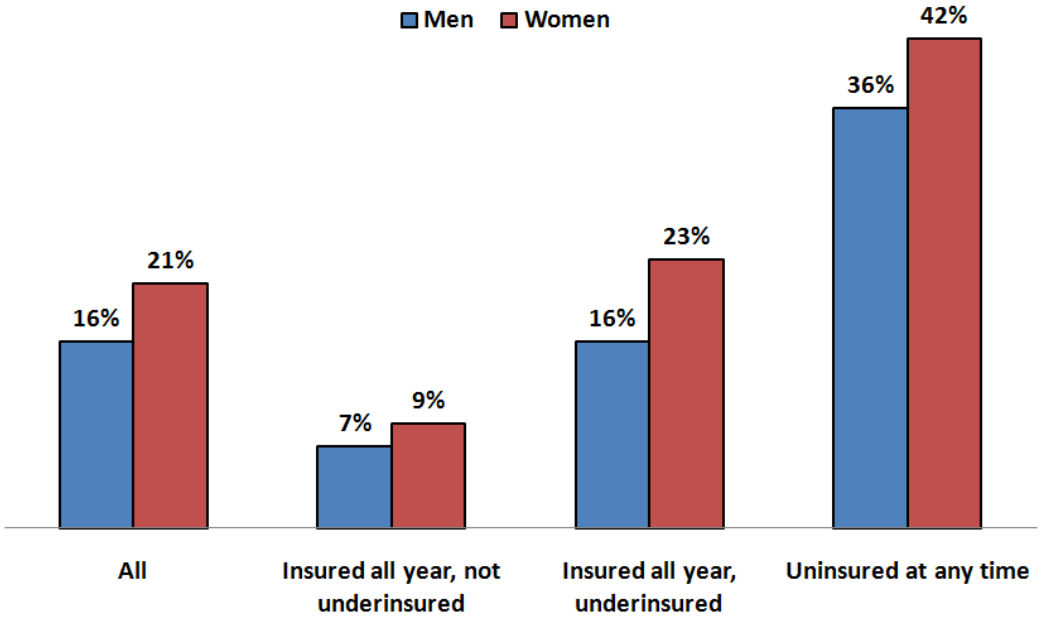
Even when compared to men with similar insurance coverage, women are more likely to report difficulty obtaining needed medical care due to cost. The gender disparity in cost-barriers to care is particularly stark for the underinsured. While nearly half (49 percent) of all underinsured men report forgoing needed medical care due to cost, 69 percent of underinsured women report foregoing needed care because they could not afford it. The persistent pay gap between men

Figure 9. Non-Elderly Adults Going Without Needed Medical Care Due to Cost, by Insurance Status and Gender



"Going without needed medical care due to cost" is defined as a positive response to one or more of the following: not filling a needed prescription because of cost; skipping recommended test, treatment, or follow-up due to cost; having a medical condition and not visiting a doctor due to cost; not getting needed specialist care due to cost. Underinsured is defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low income (<200% of the federal poverty line); or deductibles equaled 5% or more of income. Non-elderly adults are ages 19-64.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2007.

Figure 10. Non-Elderly Adults Foregoing Needed Medical Screenings Due to Cost, by Insurance Status and Gender



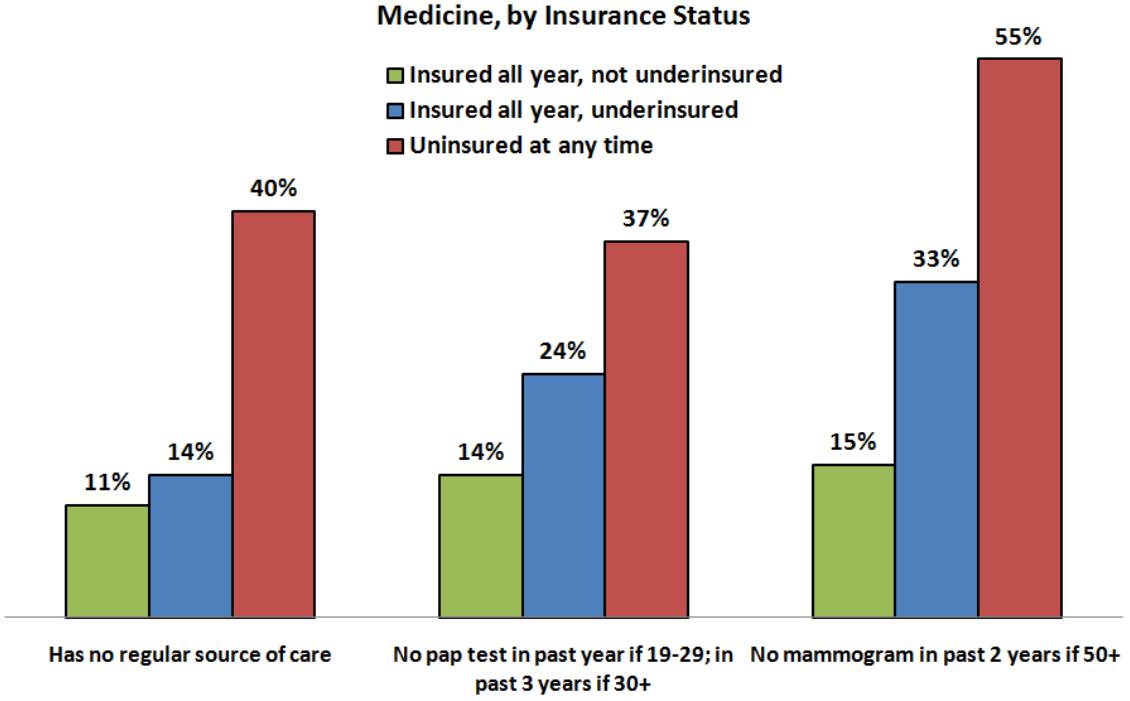
The survey leaves the definion of "medical screening" open-ended but gives mammograms, colon cancer screens, and pap tests as examples. Underinsured is defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low income (<200% of the federal poverty line); or deductibles equaled 5% or more of income. Non-elderly adults are ages 19-64.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2007.

and women may explain part of this – women earn 80 cents for every dollar earned by their male colleagues, leaving them with a smaller paycheck to cover needed medical expenses.[33] Women are also more likely than men to be the custodial parent and therefore bear responsibility for children and their accompanying expenses, which leaves less money at the end of each month to cover necessities such as medical care for the mother.[34]

Millions of women report difficulty obtaining needed *preventative* medical care. Study after study shows the importance of preventative care, both in terms of health benefits and the critical role preventative medicine can play in containing medical costs.[35] Yet women are more likely than men to go without needed preventative medical screenings due to cost. Even when compared to men with similar insurance coverage (or lack thereof), women are more likely to see cost barriers to receiving preventative care. The gender disparity is particularly sharp amongst the underinsured: nearly a quarter (23 percent) of underinsured women report foregoing preventative medical screenings due to cost, as compared to 16 percent of underinsured men.

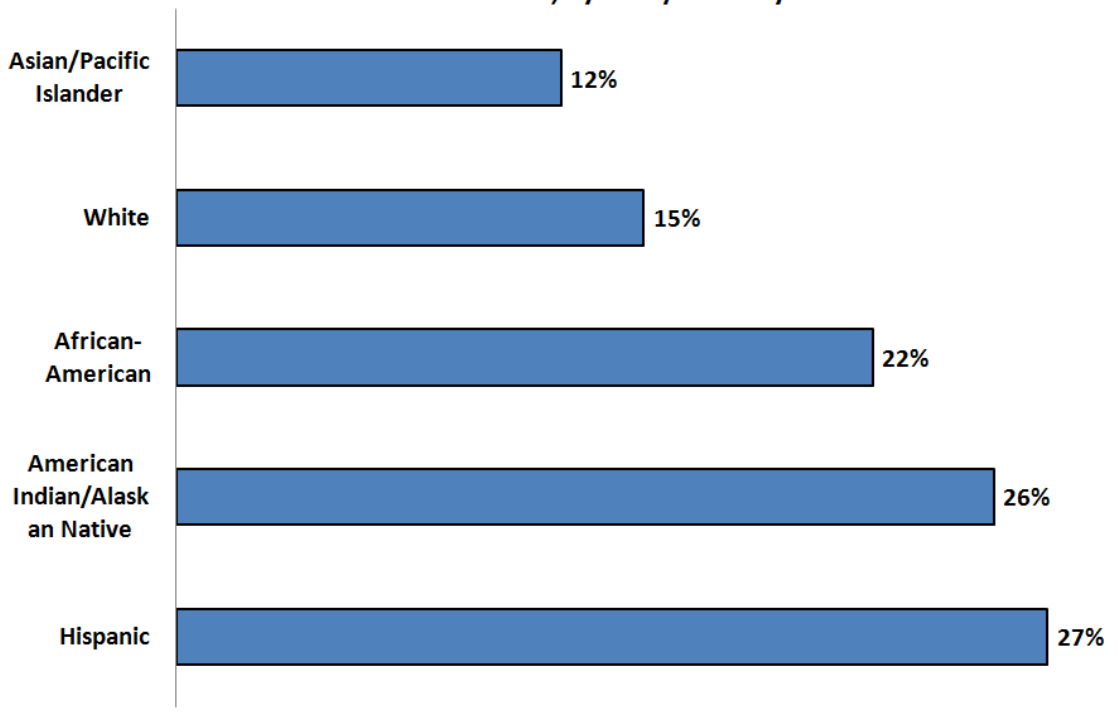
Perhaps unsurprisingly, the same groups of women who are most likely to lack health insurance coverage are likely to report problems receiving necessary medical care. 67 percent of uninsured women report that they delayed receiving needed medical care due to cost.[36] Disparities in access to preventative care are particularly troubling because of the important health benefits of preventative medicine.

Figure 11. Non-Elderly Women's Lack of Access to Preventative Medicine, by Insurance Status



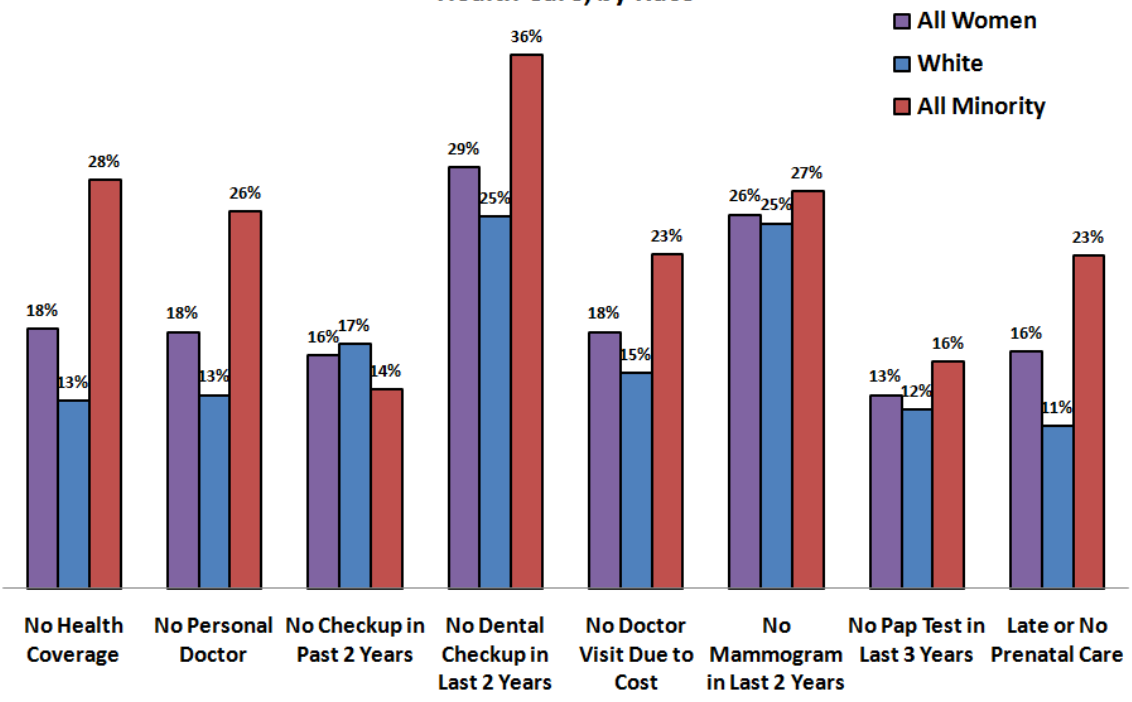
Underinsured is defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more off income if low income (<200% of the federal poverty line); or deductibles equaled 5% or more of income. Subgroups may not sum total because of rounding.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2007.

Figure 12. Share of Non-Elderly Women Reporting No Doctor's Visit Last Year Due to Cost, by Race/Ethnicity



Source: Kaiser Family Foundation, *Putting Women's Health Care Disparities on the Map*, citing data from the Center for Disease Control and Prevention, 2004-2006.

Figure 13. Share of Non-Elderly Women Reporting Difficulty Obtaining Health Care, by Race



All minorities includes African-Americans, Hispanics, Asian/Pacific Islanders, Native Americans, and Alaskan Natives.
Source: Kaiser Family Foundation, *Putting Women's Health Care Disparities on the Map*, citing data from the Center for Disease Control and Prevention, 2004-2007.

Uninsured women are far less likely than other women to receive recommended preventative care. Over half (55 percent) of women over age 50 have not received the recommended mammogram, a critical screen for breast cancer that allows providers to catch cancer in its early and treatable stages when conducted on a regular basis. Over a third (37 percent) of uninsured women have not received the recommended pap smear, a critical screen allowing for early detection of cervical cancer. And 40 percent of uninsured women do not have access to a regular doctor.

Significant and troubling racial disparities in women's access to preventative care exist. The high cost of medical care and lack of access to affordable health insurance coverage are likely to explain much of the disparity. Nearly a quarter (23 percent) of minority women report that they were unable to visit a doctor due to cost, as compared to 15 percent of white women. Lack of access to medical care due to cost is particularly problematic for Native American and Hispanic women, with 26 percent and 27 percent respectively reporting no doctor's visit in the last year due to prohibitive costs. Access to dental coverage remains highly unequal, with 36 percent of all minority women reporting no dental check-up in the last two years as compared to 25 percent of white women. Some preventative medical care remains underutilized by *all* women, regardless of race. Despite recommendations from the American Cancer Society that all women over 40 receive annual mammogram exams, a quarter of all women report no mammogram in the last two years.[37]

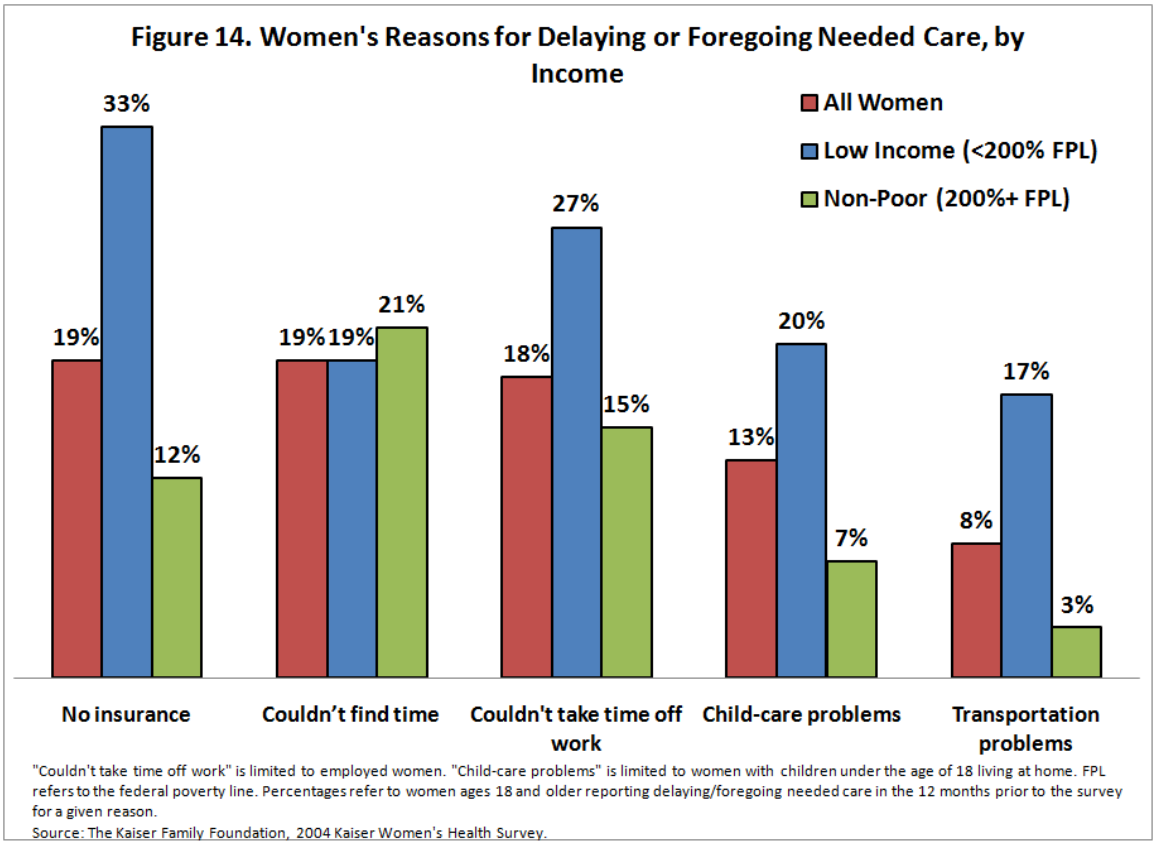
Women's reproductive health is severely compromised by un- and under-insurance, with consequences for both women and their children.

The average American woman will spend roughly five years being pregnant, recovering from pregnancy or trying to get pregnant, and three decades trying to avoid an unintended pregnancy.[38] Women's specific health concerns regarding pregnancy and childbirth, access to safe and affordable contraception, and the severe consequences of sexually transmitted diseases require continuous engagement with the health care system.

The consequences of poor access to reproductive health care are severe for women. Women are more likely than men to contract serious sexually-transmitted diseases, including genital herpes, gonorrhea, and chlamydia, and limited access to regular medical care reduces the likelihood of early detection and effective treatment of these diseases.[39] Women without health insurance are 30 percent less likely to use contraceptive methods requiring a prescription, which are more effective at preventing unintended pregnancies than over-the-counter birth control methods alone.[40] Reproductive health care providers often provide the screenings for female-specific diseases (including breast, cervical, ovarian, uterine, and endometrial cancers) that are less likely to prove fatal with early screening and treatment. Yet limited access to regular care diminishes the likelihood of preventative screenings, as noted above, and further compromises women's reproductive health.

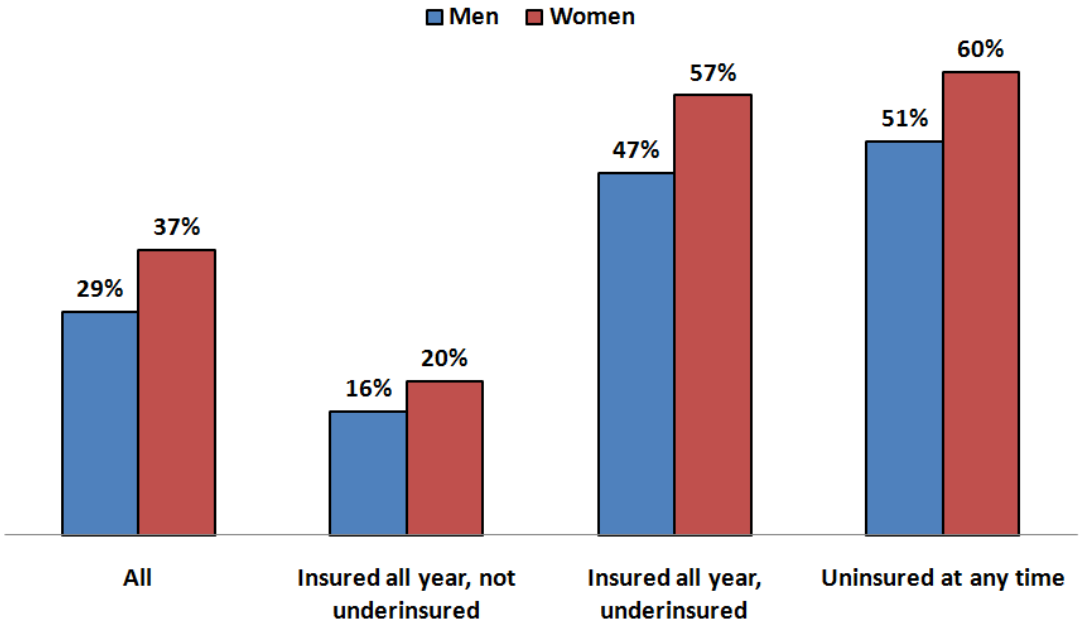
Women's limited access to quality, affordable health care also compromises children's health. Quality pre-natal and post-partum care is strongly linked to healthy outcomes for new infants as well as their mothers.[41] Large disparities in maternal mortality and infant health persist by race and income, suggesting a link between health care access and health outcomes.[42]

While lack of health care coverage remains a critically important barrier to women's receipt of adequate medical care, work-family balance challenges stand in the way of millions of women's access to quality health care.



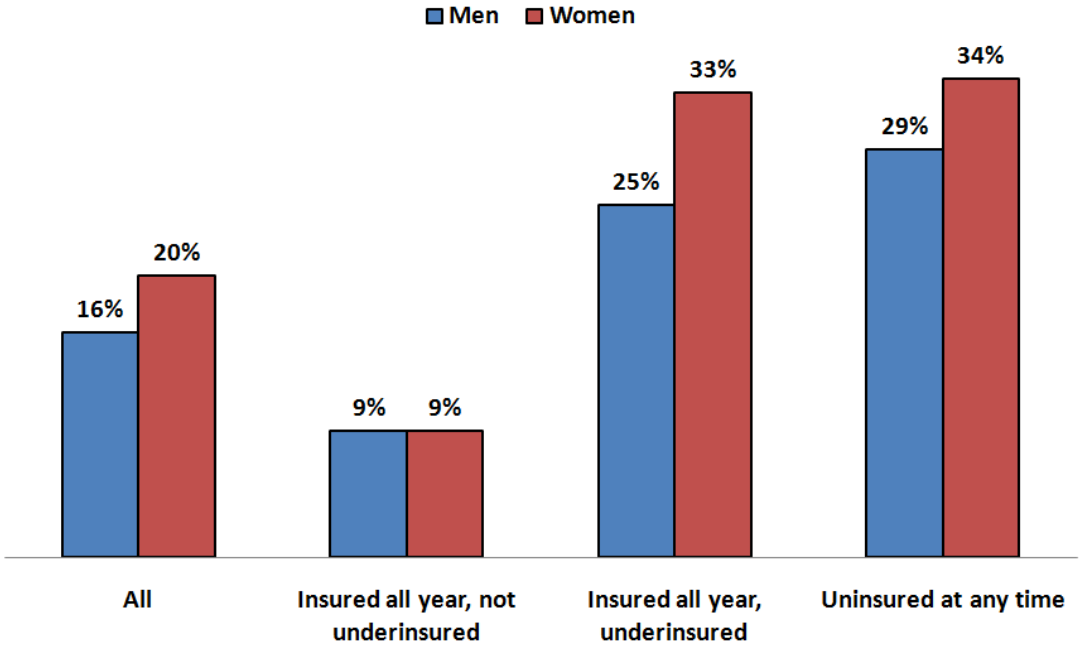
18 percent of all women report that they delayed or did not receive needed medical care because they were unable to take time off work. Over a quarter (27 percent) of all low-income women report that an inability to take time off work prohibited them from obtaining needed medical care. Similarly, 20 percent of all low-income women report that child-care problems kept them from getting needed care. Taken together, these data suggest that health care reform is only the beginning of the solution. Without national policies that assist families in balancing work and life responsibilities, millions of Americans – especially the working poor – will remain unable to access needed medical care.

Figure 15. Non-Elderly Adults with Medical Bill Problems in the Last Year, by Insurance Status and Gender



"Medical bill problems" are defined as one or more of the following: problems or inability to pay medical bills; contacted by a collection agency regarding unpaid medical bills; had to change way of life to pay medical bills. Underinsured is defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low income (<200% of the federal poverty line); or deductibles equaled 5% or more of income. Non-elderly adults are ages 19-64.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2007.

Figure 16. Non-Elderly Adults Depleting Savings to Pay Medical Bills, by Insurance Status and Gender



Underinsured is defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low income (<200% of the federal poverty line); or deductibles equaled 5% or more of income. Non-elderly adults are ages 19-64.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2007.

Inadequate insurance coverage not only puts women's physical health in danger; it also imperils women's financial health. Women bear a heavier financial burden due to un- and under-insurance than do un- and under-insured men.

37 percent of women had medical bill problems in the last year, as compared to 29 percent of men. Amongst the under-insured, 57 percent of women had medical bill problems as compared to 47 percent of men. Amongst those with no insurance at all, the share of both men and women with medical bill problems are even more dramatic – 60 percent of uninsured women and 51 percent of uninsured men.

Many Americans are taking desperate measures to cope with the medical bills that pile up following an illness. Women are more likely than men to deplete their savings accounts in order to pay medical bills. One-third (33 percent) of under-insured women deplete their savings to pay medical bills, as compared to a quarter (25 percent) of under-insured men. The disparity is comparable amongst the uninsured (34 percent of uninsured women as compared to 29 percent of uninsured men).

Comprehensive health-care reform is critical to women's physical and financial health. By simultaneously addressing coverage issues and health care costs, Congress will be tackling two problems that weigh heavily on women and their families – lack of access to affordable coverage and skyrocketing medical costs for those who do have insurance. Specifically:

- *A ban on gender rating* will put an end toward discriminatory practices that charge women substantially more than similarly-situated men for the same health benefits policies. America's health insurers support this reform, recognizing that gender rating is unfair to our nation's mothers and daughters.[43]

- *A ban on denial of coverage based on pre-existing conditions ("guaranteed issue"*) will ensure that individuals are not denied insurance coverage because of a medical condition. For millions of breast cancer survivors and others with diseases specific to women, guaranteed issue will make insurance coverage accessible and affordable.

- Inclusive *health insurance "exchanges"* will expand access to health insurance coverage for the millions of women who are not offered employer-based coverage or for those whom employer-based offerings are not adequate or affordable, especially those who work part-time and are thus ineligible for benefits and for women who lose their coverage when an older spouse becomes eligible for Medicare.

- By requiring *well-visits and preventative medicine with no cost-sharing* as part of any policy offered by an insurer participating in the health insurance exchange, health care reform will expand access to necessary and cost-effective preventative screenings and treatments for all women.

- *Caps on out-of-pocket spending* for any policy offered through the health insurance exchange will insure that a medical crisis no longer comes with the risk of a family financial crisis. *Prohibiting insurers from nullifying previously-offered coverage after costs have been incurred (no "rescissions")* will give families peace of mind in knowing that their health insurance policies must cover what they promise to cover; the rules of the game can no longer be changed mid-way through the process. For the millions of women diagnosed requiring medical attention each year, this security is key.

- The goal of health care reform is to provide affordable health insurance to all Americans, whether or not they have access to employer-provided health insurance benefits. A *public option* may be one of the cheapest ways to ensure that all Americans have access to an affordable, quality insurance plan that meets certain standards.

- *Public subsidies* to help middle-income families pay for health insurance coverage will be a boon for women, whose earnings are typically lower than men's.[44] *Medicaid expansions* will disproportionately benefit women, who are more likely than men to be poor.[45]

The proposals under discussion would allow the millions of American women who are satisfied with their health care coverage and their medical care to maintain the status quo. But it would provide an important and urgent set of solutions for the 64 million uninsured women, and millions more who are under-insured. The time has come for comprehensive health care reform.

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[1]Rustgi, Sheila et al. 2009. *Women at Risk: Why Many Women Are Foregoing Needed Health Care*. Washington, D.C.: The Commonwealth Fund. (http://www.commonwealthfund.org/~/media/Files/Publications/Issue percent20Brief/2009/May/Women percent20at percent20Risk/ PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf)

[2]Himmelstein, David et al. 2009. "Medical Bankruptcy in the United States, 2007: Results of a National Study." *The American Journal of Medicine.* 122(8)(August 2009). (http://pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf)

[3]Wood, Susan et al. 2009. *Women's Health and Health Care Reform: The Economic Burden of Disease in Women.* Washington, D.C.: The Jacobs Institute of Women's Health at the George Washington University School of Public Health and Health Services.

[4]Current as of May 2009.

[5]Had the 111th Congress not expanded the State Children's Health Insurance Program (S-CHIP) eligibility this winter, the number of children losing health coverage likely would be even greater.

[6]See the Joint Economic Committee's May 2009 report on working mothers in the recession, *Women in the Recession: Working Mothers Face High Rates of Unemployment*. (http://jec.senate.gov)

[7]Schumacher, Jessica R., et al. 2009. "Insurance Disruption Due to Spousal Medicare Transitions: Implications for Access to Care and Health Utilization for Women Approaching Age 65." *Health Services Research* 44(3)(June). (http://www.hsr.org/hsr/abstract.jsp?aid=44347877138)

[8]Bureau of Labor Statistics Household Survey. Data are for women ages 16-24.

[9]Rustgi, Sheila et al. 2009.

[10]Himmelstein, David et al. 2009.

[11]Chavkin, Wendy and Sara Rosenbaum. 2008. "Women's Health and Health Care Reform: The Key Role of Comprehensive Reproductive Health Care." New York, New York: Columbia University Mailman School of Public Health. (http://www.jiwh.org/attachments/Women percent20and percent20Health percent20Care percent20Reform.pdf)

[12]Patchias, E. and Waxman J. 2007. *Women and Health Coverage: The Affordability Gap*. Washington, D.C.: The Commonwealth Fund and the National Women's Law Center. (http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf)

[13]Institute for Women's Policy Research. 2009. *The Gender Wage Gap: 2008.* Washington, D.C.: Institute for Women's Policy Research. (http://www.iwpr.org/pdf/C350.pdf). Cawthorne, Alexandra. 2008. "The Straight Facts on Women in Poverty." Washington, D.C.: Center for American Progress. (http://www.americanprogress.org/issues/2008/10/women_poverty.html)

[14]U.S. Census Current Population Survey. 2009. *America's Families and Living Arrangements: 2008.* See Table FG5. (http://www.census.gov/population/www/socdemo/hh-fam/cps2008.html). See also the Kaiser Family Foundation's *2004 Women's Health Survey.* (http://www.kff.org/womenshealth/upload/2004-Kaiser-Women-s-Health-Survey-Presentation.pdf).

[15]Wood, Susan et al. 2009.

[16]Joint Economic Committee calculations from Bureau of Labor Statistics Household Survey, current as of June 2009.

[17]Current as of May 2009.

[18]Joint Economic Committee calculations from Bureau of Labor Statistics Household Survey, current as of June 2009.

[19]The Joint Economic Committee's calculations incorporate the number of jobs lost by men and women, the probability that a given individual had an employer-sponsored plan (either as a policy-holder or as a dependent), as well as industry-specific weights to account for the distribution of job losses and health insurance across industries. We compute job-loss related health insurance losses separately for each gender. Data for industry-specific health insurance coverage status by gender comes from the March 2008 Supplement to the Current Population Survey (CPS), which is the most recently available detailed data on health insurance coverage. Data on job loss comes from the Bureau of Labor Statistics' Establishment Survey, from December 2007 through May 2009 representing the most current available detailed data. Data for industry-specific marriage rates by gender are from the June 2009 CPS, the most recent data available. A complete methodological appendix is available from the Joint Economic Committee upon request.

[20]In one recent nationally-representative survey, amongst employers who reported taking steps to reduce costs in the last 12 months, 29 percent reported reducing health care benefits or increasing employee costs as a in the last 12 months. See Galinsky, Ellen and James. T. Bond. 2009. The Impact of the Recession on Employers." Washington, D.C.: Families and Work Institute.

[21]Schumacher, Jessica R., et al. 2009.

[22]National Women's Law Center. 2008. *Nowhere to Turn: How the Individual Health Insurance Market Fails Women*. Washington, D.C.: National Women's Law Center. (http://action.nwlc.org/site/PageNavigator/nowheretoturn_Report). See the final section on recommended policy prescriptions for a widely-agreed upon fix to the problem of discriminatory gender rating practices.

[23]Families USA/Campaign for Children's Health Care. 2006. *No Shelter from the Storm: America's Uninsured Kids*. Washington, D.C.: Campaign for Children's Health Care. (http://www.childrenshealthcampaign.org/tools/reports/Uninsured-Kids-report.PDF)

[24]See the Joint Economic Committee's May 2009 report on working mothers in the recession, *Women in the Recession: Working Mothers Face High Rates of Unemployment.* (http://jec.senate.gov)

[25]Had the 111th Congress not expanded the State Children's Health Insurance Program (S-CHIP) eligibility this winter, the number of children losing health coverage likely would be even greater.

[26]FamiliesUSA. 2009. *Understanding COBRA and Mini-COBRA Premium Assistance.* Washington, D.C.: FamiliesUSA. (http://www.familiesusa.org/issues/private-insurance/understanding-cobra-premium.html)

[27]Bureau of Labor Statistics Household Survey. Data are for women ages 16-24.

[28]Collins, Sara R. April 23, 2009. *Young and Vulnerable: The Growing Problem of Uninsured Young Adults and How Policies Can Help*. Washington, D.C.: Commonwealth Fund. (http://www.commonwealthfund.org/~/media/Files/Publications/Testimony/2009/Apr/Testimony percent20Young percent20and percent20Vulnerable/1264_Collins_New_York_Ciy_council_hearing_young_adults_04232009_testimony.pdf); National Conference on State Legislatures, 2008. *Covering Young Adults Through Their Parents' or Guardians' Health Policy*. (http://www.ncsl.org/issuesresearch/health/healthinsurancedependentstatus/tabid/14497/default.aspx).

[29]Under federal rules, state Medicaid programs must cover pregnant women and children under age 6 whose family incomes are below 133 percent of the federal poverty line and children age 6 to 18 whose family incomes are below 100 percent of the federal poverty line. Beyond that, the federal government allows states to set their own eligibility guidelines. In some states, such as Louisiana, out-of-work families qualify for Medicaid only if their incomes are at least 11 percent *below* the federal poverty line ($2,426 for a family of four). Unemployment benefits are counted as income, which means that many unemployed families find themselves without health insurance, but with too much income to qualify for Medicaid. See Galewitz, Phil. "Medicaid: True or False?" *Kaiser Health News*, July 1, 2009.

[30]Numerous states have already enacted limits to Medicaid eligibility, and several more are considering proposed cuts. See, for example: Kelley, Debbie. "Advocates say Medicaid cuts will hurt developmentally disabled." *Denver Post*, July 1, 2009. (http://www.denverpost.com/breakingnews/ci_12733118); California Budget Project. June 1, 2009. *More Than 1.9 Million Californians Could Lose Access to Health Coverage Under the Governor's May Revision*. Sacramento, CA: California Budget Project. (http://www.cbp.org/documents/090521_Health_Cuts_Statewide_Fact_Sheet.pdf)

[31]Note that the definition of "low-income" varies somewhat here because the data is from a separate survey. Income groups are defined according to absolute dollar values rather than in terms of the federal poverty line. For instance, low-income is defined as under $20,000 rather than 100 percent of the federal poverty line.

[32]Difficulty obtaining needed care is defined as reporting any one of the following four problems: 1) did not fill a needed prescription 2) did not see a needed specialist 3) skipped a recommended medical test, treatment, or follow-up 4) had a medical problem but did not visit a doctor or clinic.

[33]Institute for Women's Policy Research. 2009.

[34]U.S. Census Current Population Survey. 2009. *America's Families and Living Arrangements: 2008.* See Table FG5. (http://www.census.gov/population/www/socdemo/hh-fam/cps2008.html)

[35]For a literature review on the health benefits of prevention, see Partnership for Prevention. 2007. *Preventative Care: A National Profile on Use, Disparities, and Health Benefits*. Washington, D.C.: Partnership for Prevention. (http://www.prevent.org/images/stories/2007/ncpp/ncpp percent20preventive percent20care percent20report.pdf). For a review of the economic arguments for prevention, see Woolf, Steven H. 2009. "A Closer Look at the Economic Arguments for Prevention." *Journal of the American Medical Association* 301(2009):536-538. (http://jama.ama-assn.org/cgi/content/full/301/5/536) (subscription required). See (http://www.rwjf.org/pr/product.jsp?id=38410) for a free abstract.

[36]The Kaiser Family Foundation. *2004 Kaiser Women's Health Survey*.

[37]Note that some studies have found significant racial differences in the timing of mammograms. For instance, a recent study found that 18 percent of white women with breast cancer were inadequately screened with mammography prior to breast cancer, as compared to 34 percent of African-American women with breast cancer. See Smith-Bindman, Rebecca. 2006. "Does utilization of screening mammography explain the racial and ethnic differences in breast cancer?" *Annals of Internal Medicine* 144(8): 614-6. (http://www.ncbi.nlm.nih.gov/pubmed/16618951?ordinal-pos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DiscoveryPanel.Pubmed_RVAbstractPlus); Chan, Nancy. April 17, 2006. "Mammography screenings for breast cancer show racial and ethnic disparities." UCSF News Office. (http://news.ucsf.edu/releases/mammography-screenings-for-breast-cancer-show-racial-and-ethnic-disparities/).

[38]Chavkin and Rosenbaum. 2008.

[39]Alan Guttmacher Institute. 2002. *Sexual and Reproductive Health: Women and Men*. (http://www.guttmacher.org/pubs/fb_10-02.pdf)

[40]Culwell, Kelly R. and Joe Feinglass. 2007. "The Association of Health Insurance with Use of Prescription Contraceptives." *Perspectives on Sexual and Reproductive Health* 39(4): 224-230. For data on the efficacy of prescription versus over-the-counter birth control methodologies, see the Mayo Clinic's Birth Control Guide (http://www.nlm.nih.gov/medlineplus/birthcontrol.html).

[41]McCormick, Marie C. and Joanna E. Seigel. 1999. *Prenatal Care: Effectiveness and Implementation.* New York, NY: Cambridge University Press; Butz, Arlene M. et al. 1993. "Infant Health Care Utilization Predicted by Pattern of Prenatal Care." *Pediatrics.* 92(1): 50-54; Conway, Karen Smith and Andrea Kutinova. 2006. "Maternal Health: Does Prenatal Care Make a Difference?" *Health Economics* 15(5): 461-488; Centers for Disease Control and Prevention Health Resources and Services Administration. *Healthy People 2010*, esp. Chapter 16, "Maternal, Infant, and Child Health." (http://www.healthypeople.gov/document/HTML/Volume2/16MICH.htm#_Toc494699663).

[42]Chavkin and Rosenbaum. 2008.

[43]The health insurance industry's trade group, AHIP, has repeatedly stated its support for a ban on discriminatory rating practices, including gender rating. See, for example, Edney, Anna. 2009. "AHIP Pleads Its Case: Regulate Us." *National Journal*. May 6, 2009. (http://undertheinfluence.nationaljournal.com/2009/05/ahip-pleads-its-case-regulate.php). The insurance industry recognizes that discriminatory rating practices drive down coverage rates, as shown in multiple empirical studies. See, for example, Wachenstein, Leigh and Hans Leida. 2007. "The Impact of Guaranteed Issue ad Community Rating Reforms on Individual Insurance Markets." Seattle, WA: Milliman, Inc. (http://www.ahip.org/content/default.aspx?docid=20736). Note that the ban on gender rating practices is often referred to as part of the "guaranteed issue" policy, which would prohibit insurers from denying coverage based on pre-existing conditions, race, gender, or other basic characteristics.

[44]Institute for Women's Policy Research. 2009.

[45]Cawthorne, Alexandra. 2008.