



Women in Minnesota Need Health Reform

Today, too many women in Minnesota depend on a health care system that is failing them. They have trouble affording necessary care, face unfair insurance industry practices, or struggle to find insurance that covers the benefits they need. Health reform must ensure that all women in Minnesota and across the nation have access to the comprehensive, high-quality, and affordable health care they need.

In the absence of health reform, more and more women and families will lose their health insurance, with an estimated 67,750 Minnesota residents losing coverage between 2008 and 2010.¹ Family premiums will continue to skyrocket, reaching a projected \$25,640 for Minnesota families by 2016.² Women in Minnesota simply cannot afford the status quo. Women's wellbeing—and that of their families—depends on health reform that meets their needs.

Why Do Women in Minnesota Need Health Reform?

Women in Minnesota Face Unfair and Discriminatory Insurance Industry Practices

- ❖ Insurers in Minnesota are allowed to consider health status when setting premium rates in the individual health insurance market. Though the state limits the amount premiums can vary by health status through a “rate band,” this practice may still leave women without any affordable coverage options—especially women with chronic conditions or a history of health issues.³
- ❖ In Minnesota, insurance companies are allowed to reject a woman's health insurance application for a variety of reasons including her medical history or her current health status.
- ❖ Insurers in Minnesota can exclude coverage for certain “pre-existing” conditions; if a woman has previously had a Cesarean section, for instance, insurers may refuse to pay for future C-sections or reject her application altogether.⁴ In Minnesota, where one in four births was by C-section in 2006, thousands of women could face coverage exclusions or rejections because of this discriminatory practice.⁵

Women in Minnesota Have More Trouble Affording Necessary Health Care

- ❖ Women are generally poorer than men, and in Minnesota earn just 77 cents for every dollar men earn.⁶ Women also use the health care system more, in part due to their reproductive health needs.⁷
- ❖ Because they are poorer and use more care, women spend a greater share of their income on their health needs. Women are more likely than men to struggle with medical bills or debt, and to report cost-related problems with accessing health care.⁸ For instance, 12% of women in Minnesota report not visiting a doctor due to high costs.⁹
- ❖ Women without coverage are especially likely to experience cost-related barriers to care. In 2007, 9% of all women in Minnesota were uninsured.¹⁰
- ❖ Even women with health insurance report problems affording health care. Unaffordable cost-sharing requirements, annual limits on covered services, or health plan limits on lifetime expenditures have a disproportionate impact on women. They are more likely than men to be underinsured, meaning they have coverage that leaves their financial and physical health at risk.¹¹

Women in Minnesota Struggle to Find Coverage for the Benefits They Need

- ❖ Women, on average, visit health providers more often than men and use more preventive care. They are also more likely to suffer from a chronic condition requiring ongoing care, such as asthma or arthritis.¹² If a health plan does not cover a comprehensive set of health benefits, women may struggle to pay out-of-pocket for necessary health care that is not covered by their plan, or they may delay or skip that care altogether.
- ❖ Insurers in Minnesota are allowed to sell “small employer flexible benefit plans.”¹³ These bare-bones health plans may exclude coverage for all state-mandated benefits, many of which are critical for women—including mammograms and pap tests, diabetes care supplies, and preventive well-baby care with no enrollee cost-sharing.¹⁴
- ❖ It may be difficult for women to find coverage for maternity care in the individual health insurance market.

How Can Health Reform Help Women in Minnesota?

Health Reform Must End Harmful Insurance Industry Practices

- ❖ Health reform should impose strict regulations on insurance carriers across all health insurance markets, including the elimination of health status rating; a requirement that health insurers accept all applicants for coverage regardless of their medical history; and a prohibition on pre-existing condition exclusions.

Health Reform Should Help Women Obtain Affordable Health Insurance

- ❖ Expanding Medicaid as part of health reform can provide more low-income women and their families with access to this essential health insurance program. An expansion of Medicaid to women with incomes up to 133% of the federal poverty level (FPL), for example, would mean that up to 33,300 uninsured women in Minnesota would be newly eligible for Medicaid coverage.¹⁵
- ❖ Health reform should include subsidies to make coverage more affordable for low and middle-income families. A subsidy program available to people with incomes between 133 and 400% of the FPL, for instance, would mean that approximately 126,000 women in Minnesota would be eligible for a health insurance subsidy to help with premiums and out-of-pocket costs.¹⁶

Health Reform Should Ensure that Women Have Access to the Health Benefits They Need to Stay Healthy and Be Treated When Sick

- ❖ Health reform should require all health insurance plans to provide, at a minimum, a broad range of medical benefits (such as maternity care, prescription drugs and mental health services) and should establish a panel of medical experts, consumer advocates, and other key stakeholders to determine the details of benefit package requirements.
- ❖ Health reform should limit or eliminate cost-sharing for preventive services so that copayments and deductibles never serve as a barrier to accessing the care women need to stay healthy.

NARAL Pro-Choice Minnesota Foundation is proud to partner with the Raising Women's Voices coalition, a joint project of the Avery Institute for Social Change, the National Women's Health Network and the MergerWatch Project.

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- ¹ Families USA (2009), *The Clock is Ticking: More Americans Losing Health Coverage*, <http://www.familiesusa.org/assets/pdfs/health-reform/clock-is-ticking.pdf>
- ² Sarah Axeen and Elizabeth Carpenter, New America Foundation (2009), *The Cost of Doing Nothing: Why the Cost of Failing to Fix Our Health System is Greater than the Cost of Reform*, http://www.newamerica.net/publications/policy/cost_doing_nothing
- ³ For more information about premium rating in the individual insurance market, see: National Women's Law Center (2008), *Nowhere to Turn: How the Individual Insurance Market Fails Women*, <http://action.nwlc.org/insurance>
- ⁴ Denise Grady, *After Caesareans, Some See Higher Insurance Cost*, New York Times (June 1, 2008) <http://www.nytimes.com/2008/06/01/health/01insure.html?pagewanted=1&r=2>
- ⁵ Centers for Disease Control, National Center for Health Statistics (2009), *Vital Stats Online Database: Method of Delivery Table (subnational), 2006*, www.cdc.gov/vitalstats.htm
- ⁶ National Women's Law Center (2009), *Falling Short in Every State: The Wage Gap and Harsh Economic Realities for Women Persist*, <http://www.nwlc.org/fairpay/statefacts.html>
- ⁷ Elizabeth Patchias and Judy Waxman, National Women's Law Center (2007), *Women and Health Coverage: The Affordability Gap*, <http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf>
- ⁸ Sheila D. Rustgi, Michelle M. Doty, and Sara R. Collins, The Commonwealth Fund (2009), *Women at Risk: Why Many Women are Forgoing Needed Health Care*, <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/May/Women-at-Risk.aspx>
- ⁹ Kaiser Family Foundation (2009), *Putting Women's Health Disparities on the Map*, <http://www.statehealthfacts.org/comparemapreport.jsp?rep=31&cat=15>
- ¹⁰ National Women's Law Center analysis of 2007 data on health coverage from the Current Population Survey's 2008 Annual Social and Economic Supplement, using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html
- ¹¹ *Women at Risk*, supra note 8
- ¹² Salganicoff et al., The Kaiser Family Foundation, *Women and Health Care: A National Profile* (KFF, Menlo Park, CA: July 2005); U.S. Census Bureau, *Statistical Abstract of the United States: 2009*, "Table 159 – Ambulatory Care Visits to Physicians' Offices and Hospital Outpatient and Emergency Departments: 2006"
- ¹³ Thomas R. Pender, Minnesota House of Representatives, *Information Brief. The Minnesota Flexible Benefits Health Insurance Law: Questions and Answers*, (Oct. 2005), <http://www.house.leg.state.mn.us/hrd/pubs/flexben.pdf>.
- ¹⁴ *Ibid.*
- ¹⁵ National Women's Law Center calculations based on health insurance data for women ages 18-64 from the Current Population Survey's 2008 Annual Social and Economic Supplement, using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html
- ¹⁶ *Ibid.* Includes an estimated 65,000 uninsured women and 61,000 women who currently purchase coverage from the individual health insurance market.