Women's Health in Health Care Reform: Essential Insurance Reforms

END GENDER RATING

Gender rating is a common insurance practice under which most women are charged higher premiums than men for identical coverage.

- **Gender Rating Forces Women to Pay More than Men for the Very Same Coverage.**
  In most states, women are paying more than men for identical coverage in individual market insurance plans, even for plans that don't cover maternity care. In California, women under age 55 pay up to 39% more than men for the same coverage. Across the country, 25 year old women are charged up to 45% more than 25 year old men for the same coverage.

- **Gender Rating is Gender Discrimination.**
  Insurance discrimination based on sex should not be tolerated. Over forty years ago, the insurance industry voluntarily abandoned its practice of using race as a rating factor, despite their claim that race rating was actuarially sound. It's time to end rating discrimination against women too.

- **Gender Rating Is Seldom Actuarially Justified.**
  All insurance ratings, including those based on gender, are required to be actuarially justified. But premium rates for women vary so widely and arbitrarily among insurance companies, even within the same city, that "actuarial soundness" is unproven. In Missouri, rates for 40 year old women range from 15% to 45% more than rates for men of the same age and for equivalent coverage.

- **Gender Rating Hurts Women's Health.**
  Gender rating inflates premiums. Women who have to purchase insurance on their own may only be able to afford high-deductible plans that leave them underinsured.

ACOG Recommends:

→ Health Care Reform must end insurance rating and underwriting based on gender - in every insurance plan and every state - so that all women have access to affordable and meaningful coverage.

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PROHIBIT COVERAGE DENIALS, WAITING PERIODS, AND LIMITATIONS

Health insurers use underwriting to set terms of coverage, typically after having reviewed each person's or group's health status and claims history. Some common practices insurers use to delay, deny or limit coverage include pre-existing conditions exclusions, benefit exclusions and caps, substandard rating, re-underwriting, and cherry picking. Individuals and their families can be denied coverage for treatment of a specific health condition (exclusion rider), permanently or for a specific period of time, can be charged a higher premium because of it (substandard rate), or can be denied coverage altogether. This even still occurs in markets where these practices are illegal under federal and state law.

- **Pre-Existing Condition Exclusions Disproportionately Impact Women.**
  Women pay more for insurance, only to often find themselves without meaningful benefits. Insurers deny coverage for medical histories unique to or disproportionately affecting women, such as a past cesarean delivery, previous pregnancies, or having been a victim of domestic violence. In most states, individual market insurers are allowed to deny coverage to pregnant applicants. Even in states where they must issue a policy, insurers are usually allowed to consider pregnancy a pre-existing condition and impose a waiting period for maternity services, delaying vital care.

- **Delays and Waiting Periods Disproportionately Impact Women.**
  Women are vulnerable to fluctuations in job-based coverage: they tend to work part-time, for small firms and in low-wage jobs that don't offer benefits, and tend to be insured as dependents of employed family members. 64% of uninsured women are in families with at least one adult working full-time. 79% are in families with at least one person working either full- or part-time. Older women are more likely than men to lose coverage with death of a spouse or divorce. Young women have a higher uninsured rate than all Americans under age 65.

ACOG Recommends:

→ Health Care Reform must prohibit insurers in all states and for every plan from rejecting, delaying or imposing conditions based on an individual's health status and history, and

→ Stop insurers from classifying pregnancy as a pre-existing condition in order to deny, delay, limit, or make prohibitively expensive coverage for maternity care.

GUARANTEE MATERNITY CARE COVERAGE

Historically, insurers did not consider pregnancy an insurable event because it was viewed as a predictable expense. The 1978 Pregnancy Discrimination Act guarantees maternity coverage for women employed by firms with 15 or more employees, or who are in a union. Some states also have similar requirements. However, insurance sold in the individual and small group markets, as well as many high-deductible plans, often do not cover maternity care, or sell limited coverage for an additional fee.

- **Exclusion of Maternity Care is Sex Discrimination.**
  Over 30 years ago, federal civil rights law established as sex discrimination denial of coverage for pregnancy, childbirth and related conditions in employer-based insurance policies. Women getting coverage through small employers or the individual market should have the same protections.

- **Pregnancy Coverage Saves Money by Improving Maternal and Child Health Outcomes.** In 2005, costs associated with preterm birth, one of the most expensive pregnancy complications linked to lack of prenatal care, totaled over $26.2 billion – $51,600 for every infant born prematurely. Direct health care costs to employers for a premature baby average $41,610 – 15 times higher than the $2,830 for a healthy, full-term delivery. For every $1 spent on preconception care, anywhere from $1.60 to $5.19 is saved in maternal care costs. For every $1 spent on prenatal care, $3.33 is saved for postnatal care and $4.63 in long-term morbidity costs.

- **Employers agree.** Improving the health of children and women lowers healthcare costs, increases productivity, reduces absenteeism, reduces pregnancy-related disability claims, improves retention and supports a healthier workforce. The National Business Group on Health recommends that employers provide "first dollar-coverage (zero-cost-sharing) for preventive services, including preconception, pre-natal and post-partum care."

- **High Out-of-Pocket Costs for Maternity Care Saddle Women with Thousands of Dollars in Expenses.** Women's extra expenses for maternity coverage include high co-pays, expensive riders for coverage, waiting periods for pregnancy care, substandard rates and coverage caps that don't cover the costs of pregnancy and childbirth. A plan might cap coverage at $2,000, while the average U.S. hospital cost for an uncomplicated vaginal delivery ranges from $7,500 to $15,000 and from $11,000 to $19,000 for a caesarean delivery.

- **Maternity Coverage Exclusions Affect Men, Too.** Under some policies, a man seeking coverage for himself and his family in the small-group or individual insurance market can be denied any coverage because of his wife's pregnancy or prior cesarean delivery. This even occurs where federal and state protections exist. In those cases more aggressive enforcement is needed and consumers need to be educated about their rights.

- **When Private Insurers Reject or Exclude Maternity Coverage, the Public Safety Net Has to Fill the Gap.** 40% of all pregnancies are covered by Medicaid. In California, an increasing number of women whose births are paid for by public programs like Medi-Cal and AIM actually have private insurance, which doesn't cover maternity care. In 2008, only 26% of women insured in the California individual market had maternity coverage, compared to 82% in 2004.

ACOG Recommends:

→ Health Care Reform must guarantee essential and uniform maternity care benefits for all women, regardless of where they get their coverage,

→ Make maternity coverage portable and renewable, and offered at community rates, and

→ No cost sharing for pregnancy and preventive care.

WHY INDIVIDUAL-MARKET INSURANCE REFORMS MATTER

The private health insurance market in the US comprises three separate sectors: the individual insurance market, the small group market for employers with 2 to 50 employees, and the large group market for employers with more than 50 employees. Each sector has different rating practices and regulations which differ by state. About 17 million individuals are in the individual insurance market.

- **With Rising Unemployment, More Americans Rely on the Individual Insurance Market.** 7% of U.S. women ages 18 to 64 - 6.5 million women - are covered in the individual market, a number likely to grow as unemployment climbs.
- **Higher Out-Of-Pocket Costs Reduce Access to Care.** People in the individual market shoulder 43% of their health costs out-of-pocket, compared to 22% for people in employer plans. These costs force many individuals to forgo care.
- **As Businesses Drop or Scale Back Benefits, Group Coverage is Increasingly Unavailable.** Individual policies are more expensive for all, except the young and healthy, provide fewer benefits, and have arbitrary exclusions and denials. People are paying more for their health care at the worst possible time, when their wages are flat, energy and food prices are up, and 401ks are falling.
- **The Individual Insurance Market May Play an Important Role in Health Care Reform.** Some reform proposals would increase the number of people covered in the individual market, or even eliminate employer –based coverage altogether. Any health care reform that allows a continued role for the individual insurance market must end the individual insurance market's sex discrimination practices and guarantee affordable maternity coverage.

ACOG Recommends:

→ Health Care Reform must prohibit individual market policies that harm women's health, leveling the playing field with fair and uniform insurance rules and essential benefits including affordable, comprehensive maternity coverage.

For more information on these and other issues related to women's health in health care reform, contact Nevena Minor, ACOG Government Affairs, 202-314-2322, nminor@acog.org.

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