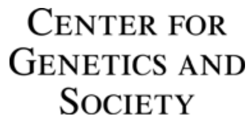
access
making choice a reality



LATINO ISSUES FORUM
A PUBLIC POLICY & ADVOCACY INSTITUTE
Advancing California's Social, Economic and Environmental Future

Maternal and Child Health Access

CALIFORNIA COALITION FOR REPRODUCTIVE FREEDOM: POLICY RECOMMENDATIONS FOR HEALTH CARE REFORM

Introduction:

Of California's 11 million women ages 19 through 64, 22%-- or 2.5 million women—are uninsured.[1] Women's health care matters: to their families, their communities and to the State of California.

Women in California are:

- More likely than men to experience unstable insurance coverage;
- More likely than men to be covered only by public programs;
- Less likely to have employer-sponsored coverage (ESC);
- Often unable to afford ESC even when eligible[2];
- Often forced to rely on pieced-together public programs focused on separate "body parts" rather than comprehensive care; and
- More likely than men to be covered as dependents rather than primary beneficiaries, leaving women more at risk for loss of insurance due to divorce, death of a spouse, and employer cutbacks on dependent coverage due to costs[3]

This document sets forth policy recommendations to ensure that *any* reforms enacted -- whether via a single payer system or by expanding existing categories of coverage to include all Californians -- protect the health of women, ensure access to affordable and equitable care and protect women's rights to safe and respectful reproductive health care.

Coverage expansions should guarantee access to care

Expanding existing public programs, like Medi-Cal, is an efficient and logical place to start to cover all uninsured Californians. However, eligibility details will be key to the impact on low-income women. 79% of uninsured women are in families with at least one part-time or full-time worker[4]; over 50% of uninsured California women themselves work either full- or part-time.[5] A special set of concerns involve the impacts of employer-sponsored coverage on low-income working women and the relationship to existing public health coverage programs.

Any expansion model should:

- Cover all state residents with family income of up to at least 300% of the federal poverty level (FPL);
- Retain the current consumer cost-sharing limits, with no more than a proportional increase for those with income over the current eligibility limits;
- Retain or improve the current scope of benefits;

- Ensure that women with family income up to 300% of poverty have access to at least the same levels of full-scope benefits, including psycho-social services and breastfeeding support, and sliding-scale subsidies as Medi-Cal and AIM currently provide;
- Streamline eligibility to create a seamless system of care and avoid gaps in coverage;
- Allow family members to enroll in the same program in order to avoid the chaos that comes with navigating the already complex system of programs;
- Include a mechanism so that women will *not* be forced to split coverage between employer-offered insurance and "supplemental" Medi-Cal *or* to give up AIM; and
- Pursue options for using employer contributions to draw down federal matching funds for women eligible for public programs; and
- Ensure access to providers by providing reimbursement that covers the cost of doing business in California.

Benefits should be comprehensive and emphasize preventive care

Any reform package should:

- Provide all women with comprehensive health coverage which includes basic health care services (Knox-Keene), preventive care, health education, care management and prescription drugs;
- Treat mental health services as a primary care service;
- Emphasize prevention by incentivizing age-appropriate preventive services, including immunizations, screenings for cancer, cardiovascular disease, diabetes, and other chronic diseases;
- Prioritize preventive services by offering health education and healthy lifestyle services such as smoking cessation and weight loss programs;
- Include comprehensive reproductive health screenings and services;
- Offer accessible medical screening and diagnostic equipment for older women and those with disabilities;
- Offer culturally and linguistically competent services including language access services, and ensure access to services for people with disabilities.

Affordability should be guaranteed

The affordability of premiums, co-pays and deductibles is a major issue for women, who, as a group, earn 81% of what men do. Nearly half of all personal bankruptcies result in part from medical expenses.[6] Numerous studies, including government-funded studies, show that even small increases in premiums or co-pays can have dramatic impacts on low-income people's enrollment and use of health benefits programs.[7]

Any reform package should:

- Ensure affordability and protect low-income women from premiums, co-pays and deductibles beyond their ability to pay.
- Avoid mandating the purchase of health insurance products that are unaffordable and do not guarantee access to a basic set of benefits.
- Enact health insurance reforms in both the group and individual market, prioritizing guaranteed issue and cost containment measures.

Family planning services should be guaranteed and prioritized

California has the largest and most successful family planning program in the country, preventing unintended pregnancies and cases of sexually transmitted infections and saving the state $5.33 for every dollar spent.

Any reform package should:

- Include support for women to decide when and whether to become a parent;
- Preserve current pharmaceutical and contraceptive equity benefits;
- Ensure access to a comprehensive array of reproductive health services, including, but not limited to, contraception, testing and treatment for sexually transmitted infections, and culturally and linguistically appropriate education about sexual health and reproduction;
- Ensure access to comprehensive services and information by avoiding overbroad refusal clauses; and
- Leave Family PACT intact and available to individuals outside of coverage expansion efforts.

Pregnancy-related services should be guaranteed and prioritized

Pregnancy and childbirth are the primary reason for hospitalization for women during childbearing years, and account for almost 25% of hospitalizations nationwide.[8] In California, over 550,000 births occur every year and insurance coverage plays an important role in improving pregnancy-related health care and health outcomes. Uninsured women are much less likely to enter prenatal care early than those who have coverage, resulting in an increase in costly preterm births.[9]

Any reform package should:

- Include comprehensive pregnancy-related services, including prenatal care, prenatal genetic diagnosis, labor and delivery and abortion;
- Prioritize programs and services that incentivize early entry to prenatal care; and
- Include services to ensure safe pregnancies, safely ending pregnancies and services for women who might become pregnant in the future; and
- Leave AIM intact and available to individuals outside of coverage expansion efforts.

Conclusion:

We applaud the efforts of the legislature and the administration to expand health coverage to uninsured individuals. Health insurance is one of the key factors in women's ability to access health care services, and as we move forward with reforms for the health care system, we must take into account women's multiple roles, the unique role of gender in health and health care and create a seamless system of care for women across the lifespan, and include the principles set forth above.

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[1] Kaiser Family Foundation (KFF), Women's Health Policy Facts, *Health Insurance Coverage of Women Ages 18 to 64, by State, 2004-2005* (February 2007): 11,115,000 in California x 22% = 2,445,300.

[2] Kaiser Family Foundation (KFF), Women's Health Policy Facts, *Health Insurance Coverage of Women Ages 18 to 64, by State, 2004-2005* (February 2007).

[3] KFF, *Women's Health Policy Facts* (February 2007), p. 2 (national data).

[4] KFF, *Women's Health Policy Facts* (February 2007), p. 2 (national data).

[5] Wyn, R., UCLA Center for Health Policy Research, *Women's Health Insurance Coverage In California* (November 2006), p. 2.

[6] Trude, S., "Patient Cost-Sharing: How Much Is Too Much?", Center for Health System Change, (December 2003), p. 3, citing, 5 Jacoby, M. et al., "Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts," *New York University Law Review*,Vol. 76, No. 2 (May 2001).
[7] KCMU, "Health Insurance Premiums and Cost-Sharing: Findings From the Research On Low-Income Populations" (March 2003); Ku, L., et al., "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings", Center on Budget and Policy Priorities (July 2005).
[8] AHRQ, "Hospitalization in the United States, 2002: HCUP Fact Book No. 6" Health Care Cost and Utilization Project. Available at: www.ahrq.gov/data/hcup/factbk6/factbk6.pdf.
[9] Braverman et al., *Promoting Access to Prenatal Care: Lessons from the California Experience,* The Henry J. Kaiser Family Foundation 2003