



Health-care costs are skyrocketing. And for the 17 million uninsured women in the United States who suffer disproportionately, the prognosis isn't good. It's time to get serious. This social ill isn't going to cure itself.

Women's health has made tremendous progress in a generation, yet the mainstream medical and policy communities still often fail to recognize the special challenges that many women face in affording and accessing comprehensive health care.

Women live longer, are more likely to have chronic health problems, and use more health-care services over the course of their lives than men. Their interactions with the health system are shaped by their reproductive health concerns, as well as their roles managing the health of their families — doing everything from making sure their children go to the pediatrician to caring for ailing parents, often at great economic and emotional cost.

Overall, two-thirds of 18- to 64-year-old adults are insured through the workplace. However, a woman is less likely to be insured through her own job and twice as likely to be covered as a dependent. When this is the case, she risks losing her coverage if she divorces, is widowed, or her spouse becomes unemployed. Her coverage relies on her husband's employer, which could drop family coverage, raise premiums, or increase out-of-pocket costs to unaffordable levels.

According to Kaiser Family Foundation research, premiums have risen 73 percent since 2000, outpacing both inflation and wage increases. In 2005, the average annual premium for a family of four was \$10,880, with workers contributing \$2,713. Disturbingly, cost pressures have become barriers to health care — even for women with private insurance. In 2004, one in six privately insured women said she postponed or went without needed care because she could not afford it, according to a national Kaiser Foundation survey.

Moreover, the number of uninsured women is growing, and this translates into poorer health outcomes for rising numbers of women. There are 17 million uninsured women, according to the US Census. And although we have more tools for early detection than ever before, these women are much more likely to go without needed care. They often fall far short of meeting recommended levels of preventive care like mammograms and pap smears.

Of the 92 million women in the United States ages 18 to 64, 19 percent do not have insurance.

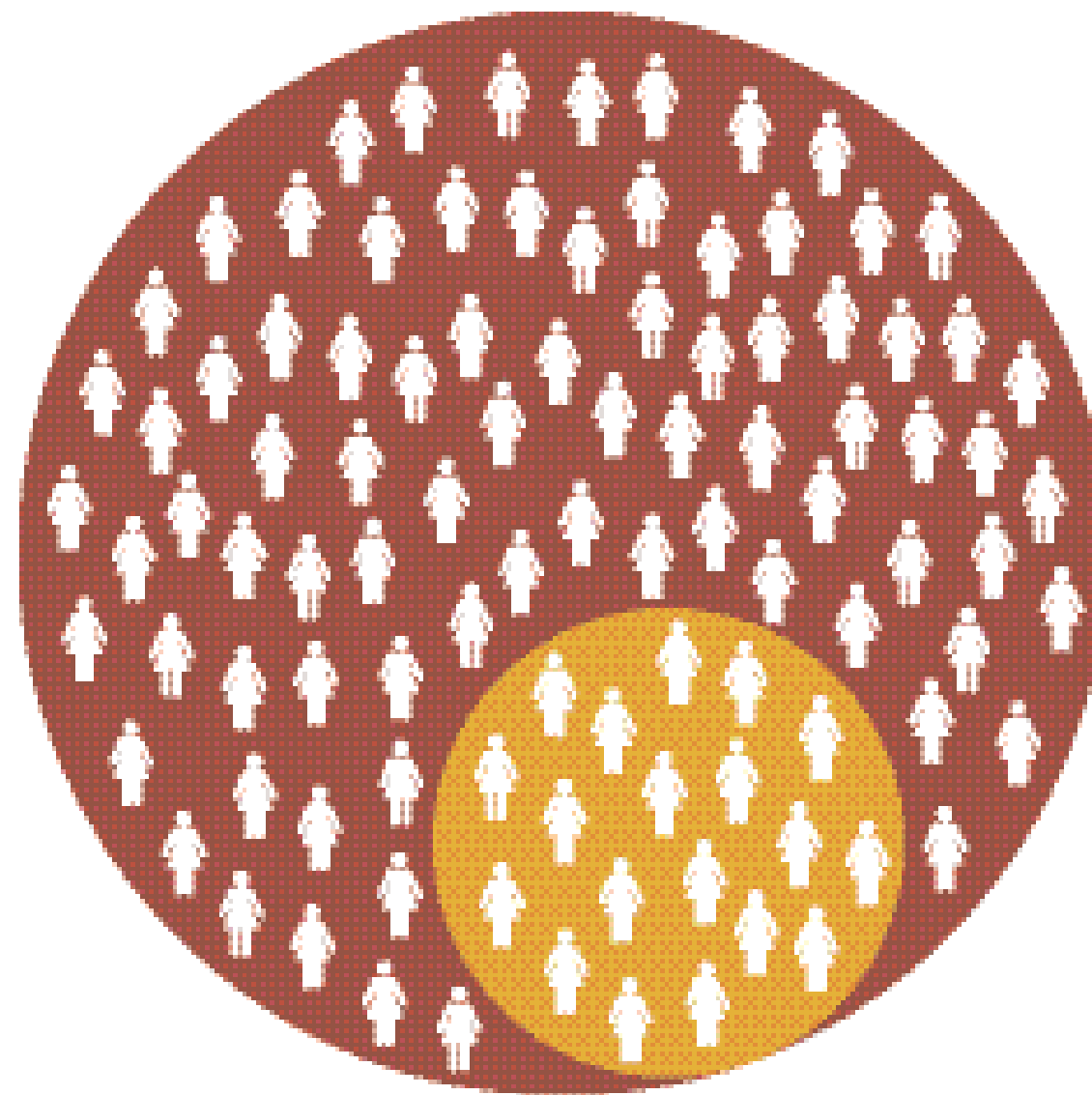
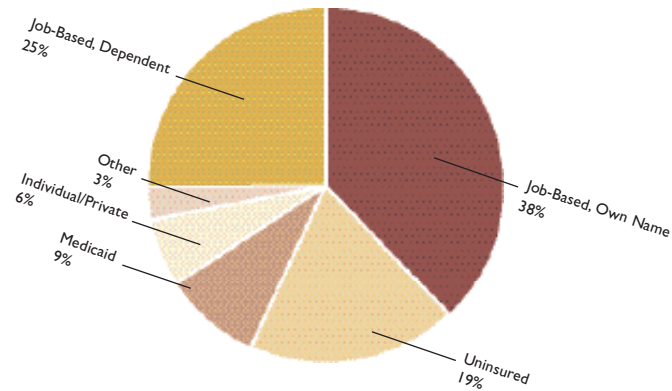


Illustration based on the Kaiser Family Foundation/Urban Institute analysis of March 2005 Current Population Survey, Bureau of Census.

Women's Health Coverage



Note: Other includes Medicare, Champus, and other sources of coverage.
 Courtesy of the Kaiser Family Foundation/Urban Institute analysis of March 2005 Current Population Survey, Bureau of Census.

Uninsured patients with breast cancer, colorectal cancer, and melanoma — who typically do not get necessary preventive care, early diagnosis, or treatment — die sooner than those with coverage. And uninsured patients who are hospitalized for heart attacks are treated less aggressively and are more likely to die than those with coverage.

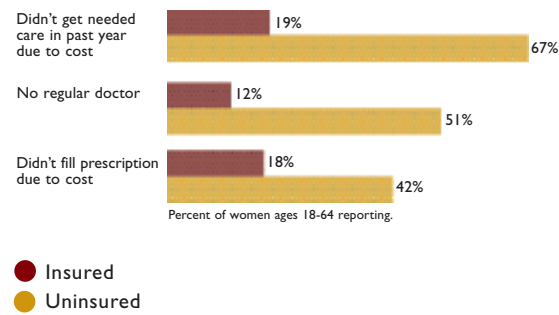
In fact, an Institute of Medicine study found that an estimated 18,000 people die unnecessarily each year because they do not have insurance. These calculations, however, fail to capture the unnecessary pain and disability endured by people who lack the coverage or money to get needed care. While many think that the uninsured can turn to public clinics and hospitals, communities often lack these resources and, where they do exist, they cannot compensate for true health coverage.

For many women, publicly funded programs like Medicaid and Medicare are critical safety nets. Medicaid, the state and federal program for the poor, is a vital source of coverage for millions of poor women of all ages. Nearly three-quarters of adults on the program are women. It foots the bill for 40 percent of births, over half of publicly funded family planning, and half of nursing-home care. Program eligibility is limited, however, to those who are low-income and disabled, mothers, pregnant, or 65 or older. Other women typically do not qualify, no matter how poor they are.

Unfortunately, the truth is that it is very costly to serve the sickest, poorest, and most disabled of our society, and as policymakers look for ways to control government spending, Medicaid is often a target. Recent federal legislation has cut funding for the program and made policy changes that will give states far more latitude to charge their low-income beneficiaries higher premiums and co-payments.

Like Medicaid, Medicare is also essential for older women and those with disabilities. Because women live longer than men, they account for more than half of the program's beneficiaries and

Barriers to Care, by Insurance Coverage



Courtesy of the Kaiser Family Foundation, 2004 Kaiser Women's Health Survey.

nearly three-quarters of those 85 and older. For many older women, poor health is exacerbated by economic hardship: A lifetime of lower earnings and time off from the workforce to care for family members translates into lower Social Security and pension payments. And because older women have disproportionately lower incomes, even with the new Medicare drug benefit, the out-of-pocket costs — including premiums, cost-sharing, and co-payments — can be troublesome, especially for those without supplemental coverage.

Despite the gravity of the cost and coverage gaps faced by millions of Americans, most of the proposals being actively considered by policymakers would make only modest changes in coverage. In recent years, some policymakers and employers have begun to embrace so-called “consumer-directed” models such as high-deductible health plans coupled with tax-protected health savings accounts that would pay for expenses not covered by the plan. Proponents claim that consumers will make better and more economical choices if they have to pay directly for health services. But such arguments rely on the assumption that access to information about health quality and costs will improve significantly.

These plans may work adequately for people with limited needs, but individuals with chronic illnesses or unexpected expenses could find themselves facing extremely high out-of-pocket costs. There are unanswered questions about the extent to which these plans will cover key women's expenses, such as maternity care. And because many women have low incomes, they are less likely to be able to afford to add to their health accounts beyond their employers' contributions, leaving them potentially exposed to additional expenses.

It is no wonder that health care is a driving force in how women vote. In the days ahead, as Americans consider proposals that promise to improve coverage and control rising costs, it is crucial that we examine them through a women's lens. >

Many women aged 18 to 64 have not received lifesaving screening tests in the past two years. Uninsured women, in particular, face alarming odds.



Note: mammogram among women 40-64; colon cancer screening among women 50-64.
 Courtesy of the Kaiser Family Foundation, 2004 Kaiser Women's Health Survey.

How Nursing-Home Costs Put Women in the Poor House

Long-term care is what you need when you are too frail, disabled, or sickly to care for yourself, and not sick enough to be in a hospital. Costing upward of \$70,000 a year, long-term care is beyond the means of most Americans. And it is a women's issue, by default. Women live longer. They are poorer and are more likely in old age to be living alone. In fact, women make up 75 percent of the nursing-home population. And they are apt to experience the problems and hardships surrounding long-term care twice: first as caregivers, then as patients.

Contrary to popular belief, Medicare — the federal health insurance program that covers people 65 and older — does not generally pay for long-term care. Despite a lifetime's savings, many Americans simply cannot afford long-term costs and must turn to Medicaid, a federally funded but state-operated poverty program. States are required to provide nursing home care under Medicaid for any low-income resident over 21. But to qualify, the middle-class elderly have to spend down most of their assets and income. While special rules exist — supposedly intended to prevent the impoverishment of the spouse (usually the wife) living in the community while the other spouse resides in a nursing home — they leave much to be desired.

So more and more women, in particular, are forced to pauperize themselves — depleting their life savings until they are poor enough to qualify for coverage. To add insult to injury, by the time many women need long-term care for themselves, their family assets have already been exhausted by their husbands' long-term care.

To address complaints that Medicaid recipients had transferred assets to their children or elsewhere in order to become eligible for assistance, the federal government used to require that all transactions “looking back” three years be documented, to prove that they were made at fair market value. Under the Deficit Reduction Act of 2005, that period has been extended to five years, and other rules have been made stricter. Providing such extensive documentation is an extreme burden for many elderly patients and their spouses. And for those suffering from dementia, a common diagnosis that requires long-term care, it may be impossible.

The number of people who actually try to evade Medicaid eligibility requirements by transferring assets is believed by most to be very low — certainly a lot lower than those using legal tax shelters. Yet by reducing the number of those eligible and delaying entry into nursing homes, the government is projected to save more than \$2 billion over the next five years. The human cost of care delayed or denied has not been calculated.

In the end, the real challenges in finding and affording quality care have little to do with asset transfers. A true fix to the long-term care problem will be twofold: to devise a system that delivers such care as part of a universal social insurance program like Medicare, and to address the issue of providing quality professional care at home as long as possible. For women, the fix couldn't be more fundamental. Their lives depend on it.
— Suzanne Crowell

