



HEALTH CARE REFORM: A WOMEN'S ISSUE FOR MINNESOTA

A summary & status report by the Minnesota Women's Consortium

May 12, 2008

- ★ What do you mean by “health care reform”? ★ Why is this a women’s issue?
- ★ What is being done to make health care more accessible & affordable & put women at the center?

Health care reform generally refers to efforts to improve health care and make it more accessible and affordable to everyone. In discussions the Consortium has hosted in recent months, many people are also advocating for more holistic thinking about change, moving beyond the “medical model” and narrow definitions of “health” as something delivered by doctors, clinics, and insurance companies. There has also been much research, study, and discussion of the social and economic aspects of health and health care: women, people of color, and older people face extra health problems, costs, and barriers to care.

At this writing, the Minnesota state legislature has been considering an ambitious health care reform bill for many months. The outcome for that bill for this year is not yet known – but in all cases there is much more work to be done. The National Women’s Law Center project called “Reform Matters” has assisted Minnesota women’s organizations working on this issue, and this summary reflects their considerable research. The Minnesota Women’s Consortium has undertaken these activities so far on this topic:

- Included four health-related issues in its *Women’s Action Plan*, downloadable from www.mnwomen.org:
Insurance - eliminate discrimination; cover prevention, home care, mental health, etc; *Reproductive freedom*
Special health concerns- AIDS, heart disease, breast & ovarian cancer; & *Prescription drugs*.
- Highlighted this issue in presentations by 20 presidents of member organizations at the **Presidents on Presidents’ Day** Capitol event in February 2008, interacting with 6 state legislators who serve on health care committees (the presidents’ statement can be downloaded under “Publications” at www.mnwomen.org);
- Convened a **spring membership meeting** on the topic of “Women & Health Care” in April 2008, featuring information from 10 member organizations working on these issues as well as a presentation by Lisa Codispoti, senior health advisor to the National Women’s Law Center;
- Convened a meeting on May 1 of **health care expert/provider groups** interested in exploring collaborative work on these issues. The Consortium has identified 35 member groups with health expertise.

Why is health care a women’s issue?

- Since women are a majority of poor people and have lower average earnings than men, they are disadvantaged because of the strong relationship between health and income. Medicaid insures nearly twice as many women as men. Women are more likely to be under-insured, have higher out-of-pocket costs, and women have greater difficulty affording health care services even when they are insured.
- Women are less likely than men to have health insurance coverage through their own employer and more likely to obtain coverage from their spouses; are more often excluded from coverage because they work part-time or because of their status as dependents; and use more health care services than men, and so are in greater need of comprehensive coverage.
- Additional health disparities related to race, ethnicity, sexual orientation, disability, and other factors underscore that the problems faced by many women are even greater than the overall numbers suggest. For example, Black women are significantly more likely than White or Hispanic women to die from coronary heart disease, breast cancer, and stroke. Over half of the women in the U. S. report having been raped and/or physically assaulted in their lifetimes – including 64.8% of Native American & Alaska Native women.
- All 50 states met only one of the Healthy People 2010 benchmarks, covering an annual dental visit, while these benchmarks were missed by all states: health insurance, Pap smears, obesity, eating 5 fruits & vegetables a day, high blood pressure, diabetes, life expectancy, infant mortality, poverty, and the wage gap.
- Coverage for specific conditions affecting women is often excluded from general insurance plans. Goals for procedures like mammograms, Pap smears are met in fewer states than three years ago.
- Nationally, nearly half of all pregnancies are unintended, thereby missing by a substantial margin the national goal to reduce unintended pregnancies to 30% or less of all pregnancies.
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- With women representing the large majority of caregivers for children and parents, paid family leave policies are vital for family health – but available only in California and Washington state.

How does Minnesota fare on these measures of women's health?

According to *Making the Grade on Women's Health*, Minnesota's overall rating is #2 in the nation. However, even the number 2 rating is characterized as "Satisfactory Minus." Selected measures and how Minnesota is doing:

- Only 7% of white women in Minnesota lack health insurance – but 14% of Black women, 13% of American Indian/Alaska Native women, 14% of Asian/Pacific Islander women, and a shocking 47% of Hispanic women in Minnesota do not have health insurance.
- 91% of white women in Minnesota receive first trimester prenatal care – but only 75% of Asian women, 72% of Black women and 71% of Hispanic women receive this care.
- The state overall receives a satisfactory rating on the percentage of all women who do not undertake leisure-time physical activity (18%), but 33% of Hispanic women and 42% of Black women don't undertake it.
- Minnesota receives a failing grade on these aspects of prevention based on overall percentages (women of all races combined): obesity, eating five fruits and vegetables a day, smoking, and binge drinking.
- Stroke death rates and lung cancer death rates for women vary dramatically by race, and Minnesota ranks "unsatisfactory" on the stroke death rate and "failing" on the lung cancer death rate.
- The report card also notes Minnesota's status on measures such as chronic conditions, reproductive health, mental health, violence against women, living in a healthy community, and economic security and education.
- In rating women's access to health insurance and services, the state met many policy goals including these: Medicaid eligibility for pregnant women & working parents; public insurance for childless adults; parity on mental health, eating disorders, and depression; Medicaid coverage for breast & cervical cancer treatment; Medicaid waiver for family planning; private insurance coverage & public funding of abortion; direct access to OB-GYN in managed care; mandated Pap smear & mammogram screening coverage; food stamp outreach & nutrition education; and several economic security and anti-discrimination policies.
- Some of the recommended policy areas where Minnesota has no policy or a harmful policy: Medicaid eligibility for aged and disabled, presumptive Medicaid eligibility for pregnant women, ombuds staffing levels for long-term care, access to emergency contraception, assistance for victims of domestic violence and sexual assault, chlamydia screening, osteoporosis and colorectal cancer screening, sexuality education in public schools, and restrictions on carrying concealed weapons.

Assessment of Minnesota's efforts at health care reform.

At this writing a health care reform bill has been approved by a House-Senate conference committee and is expected to be sent to Governor Pawlenty very soon. It is not certain whether he will approve or veto this legislation. While the bill does not include all the changes recommended by task forces appointed by the governor and the legislature earlier this year, it represents a start on wide-reaching reform.

According to the *Star-Tribune*, the bill in its final form "would start a statewide campaign to reduce smoking and obesity, offer public data on the quality and costs of doctor and hospital services, certify doctors and clinics that provide "medical homes" with comprehensive and coordinated care, and expand eligibility to add about 40,000 people to MinnesotaCare, the insurance program for lower-income working poor." (5/12/08 story) If signed, author Senator Linda Berglin said the bill is expected to cut medical costs by about 10 percent by 2015. The bill would begin to shift physician payments toward their quality of care rather than the traditional fee for service model. The costs of reform would come from the Health Care Access Fund created by the provider tax. However, this fund has repeatedly been used in past years to balance the state budget, and the governor's most recent proposal is to use \$48 million of this fund in the next three years for this purpose – which would reduce the amount available for increased access to health care.

In the future...

Please stay tuned for an assessment of Minnesota's health care reform and its effects on women – whether this bill becomes law or not. We expect member organizations of the Minnesota Women's Consortium will play an active role as the reform process continues – some in planning and proposing needed changes, and many others in supporting the message to "remember the women" at every stage in the process.

