Bush Health 'Reform' Agenda: Implications for Reproductive Health

Throughout the 2004 campaign, President Bush repeatedly emphasized the need to improve health care coverage, particularly for the millions of uninsured Americans. However, an examination of the various approaches being advanced by the administration and its allies indicates that the proposals would do little to expand coverage to the uninsured. Moreover, these approaches have serious implications for the coverage available to low-income Americans in general and for their reproductive health care specifically.

By Rachel Benson Gold and Adam Sonfield

Health care was a front-burner issue for both candidates in the recent presidential campaign. Concern over care was driven by the twin and interrelated issues of rising health care costs and the growing number of Americans who lack the insurance coverage needed to pay for those costs. In 2003, 45 million Americans—a number that has grown steadily in recent years—lacked insurance coverage, according to U.S. Census Bureau data.

These issues are as critical for reproductive health care as they are for health care in general. Rising costs are putting an increasing burden on both the recipients and providers of reproductive health care ("Nowhere But Up: Rising Costs for Title X Clinics," *TGR,* December 2002, page 6). At the same time, a large proportion of women of reproductive age are uninsured.

President Bush devoted significant attention to health care issues throughout the campaign. In fact, an entire section of the Republican Party's platform was entitled "True Solutions for Affordable, High-Quality Care," and his administration's FY 2006 budget trumpeted the same themes. But a close examination of the proposals made by the administration and its allies suggests that a primary motivation is adherence to conservative, free-market ideology. In fact, some of the proposals, if adopted, would do little if anything to address the problem of the uninsured, and others might even exacerbate it—either by increasing the number lacking insurance or by undermining public programs such as Medicaid.

Underlying Themes

Two important and closely related themes run through both the policy options and the accompanying rhetoric. The first of these themes is the notion that government should be less involved in determining the content and scope of insurance coverage. According to this theory, insurance is a matter for markets, not governments.

The second theme is the notion of empowering consumers, and making health insurance and health care more "consumer-driven." The very first paragraph of the Republican platform from the 2004 elections put the issue in sharp relief: "We want more people to own and control their health care."

Several of the approaches to "empowering" consumers would provide a tax subsidy to individuals aimed at making new types of consumer-driven coverage more affordable and attractive. Many conservatives argue that as more Americans see these plans as desirable, private insurance companies will flock to provide them with new options.

Association Health Plans

One frequently mentioned proposal would create insurance pools known as Association Health Plans (AHPs). These plans would allow professional and trade associations to use their purchasing power to offer insurance coverage to their members, ideally at a lower cost than employers could do individually. Employers belonging to these organizations could purchase that coverage for their employees and their dependents. The administration has often stated its support for this approach, and although legislation to establish these plans passed the House in 2003, it stalled in the Senate.

A key problem with AHPs, however, is that they would likely be stripped-down plans—cheaper largely because they may exclude preventive care and other services and leave enrollees at greater risk. In particular, one of the biggest attractions for employers is that AHPs would be exempt from states' mandated-benefit laws, several of which relate directly to reproductive health care. For example, since the 1970s, every state has had a law to ensure that newborns are covered from birth and that costly conditions discovered in the first few days of a baby's life are not excluded from coverage, as had been the practice of insurers until that point.

In addition, some states require that policies cover newborn screening, pregnancy complications, cervical cancer screening, infertility treatment, and breast cancer

diagnosis and treatment. Twenty-one states require plans to cover contraceptive drugs and devices if they cover prescription drugs in general. These laws are widely acknowledged as vital to the improvement in contraceptive coverage over the last decade ("New Study Documents Major Strides in Drive for Contraceptive Coverage" and "Contraceptive Coverage: A 10-Year Retrospective," *TGR,* June 2004, pages 4 and 6).

Health Savings Accounts

Another high priority of conservative policymakers and advocates is to encourage Health Savings Accounts (HSAs)—tax-sheltered accounts that individuals could establish and use to pay for medical expenses. Any unused balance in the accounts would accumulate over time. People who opened these accounts would be required to purchase so-called high-deductible coverage—either on their own or through an employer or other group—that would kick in once the individual or family had incurred a preset amount of out-of-pocket expenditures. Supporters hope that if consumers feel as if they are spending their own dollars for health care, they would be more cost-conscious and make wiser choices about the care they purchase.

Congress established HSAs as part of the same 2003 legislation that created a drug benefit in Medicare. The Bush administration is proposing to encourage enrollment in HSAs by allowing individuals to claim a tax deduction for the cost of purchasing high-deductible plans. In addition, the accounts have been included among the options offered to participants in the Federal Employees Health Benefits Program, where the issue has been joined with the ongoing controversy over "faith-based" plans (see box).

Opponents of the administration's HSA proposal believe that the tax deduction would do little to convince Americans to purchase this coverage. According to the Center on Budget and Policy Priorities, the value of the proposal to the individual would rest on the size of the tax deduction that could be reaped from purchasing the high-deductible insurance. Because tax rates increase as

The Emergence of Faith-Based Health Plans

Approaches to health care reform such as HSAs and AHPs have mostly been promoted by economic conservatives under the rubric of consumer control. Yet, this is one area where the economic and social wings of the conservative movement may be converging: Consumer control over health insurance would also mean that religious consumers could purchase insurance that better conforms to their faith.

The Heritage Foundation hosted a symposium on "faith-based" health plans in June 2004. The speakers advocated a two-pronged approach. The first approach would be to remove "objectionable" requirements, such as state contraceptive coverage mandates, from current insurance plans. Second, they endorsed the idea of plans sponsored and designed by faith-based organizations as an answer to their wide-ranging concerns about current and emerging bioethical issues—from abortion, infertility services and family planning to end-of-life care, genetic engineering and treatments based on stem cell research and cloning.

According to analysts at Heritage, faith-based health insurance might be encouraged by a new twist on the AHP approach proposed by the Bush administration. In addition to allowing small businesses to purchase coverage through AHPs, the administration's proposal would allow churches and other community organizations to band together across state lines to offer coverage for their members.

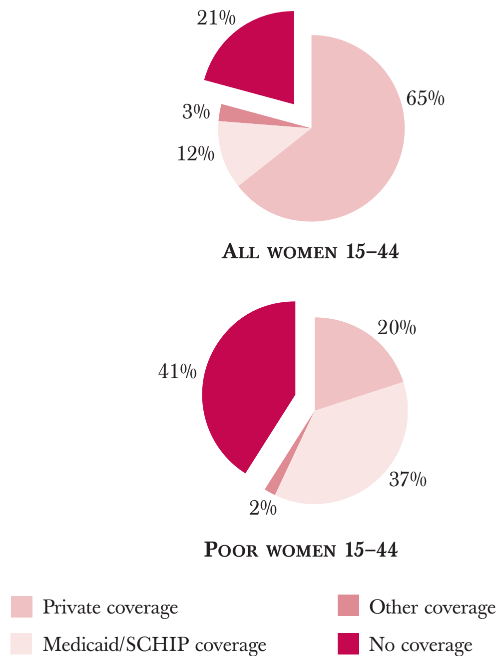
The Bush administration showed its support for the faith-based approach in yet another way when the Federal Employees Health Benefits Program announced late last year that a faith-based plan combining an HSA and high-deductible insurance would be made available in parts of Illinois. The plan, designed in accordance with Catholic doctrine, excludes coverage of certain types of reproductive health services, including contraception, abortion and some types of fertility treatment.

Advocates for reproductive health and for separation of church and state have a number of objections to the concept of federally funded faith-based insurance. The National Women's Law Center, for instance, has expressed concern about whether federal employees would be given ample notice about excluded services. Moreover, advocates worry that employees' wives and daughters would have no say at all in the decision to enroll in a faith-based plan. A third concern is that federal employees would choose a particular faith-based plan because it seems least expensive or because of the doctors in the plan's network, only to end up struggling to pay out-of-pocket to address their reproductive health needs because of religious restrictions.

This concern is even more pronounced when taken out of the context of federal employees' insurance. If it is private employers, instead, selecting insurance plans—based, again, on such factors as cost and provider networks—individual employees and their families may have no choice but to enroll in a faith-based plan that would neither meet their health care needs nor conform to their moral and religious beliefs.

Women Without Coverage

Although one-fifth of American women of reproductive age are uninsured, the proportion doubles for those who are below the federal poverty level.



Source: The Alan Guttmacher Institute, special tabulations of data from the Current Population Survey, 2004.

income increases, the deduction is a much better deal for the affluent; workers who do not earn enough to pay income tax would get no benefit whatsoever.

HSAs themselves have the exact same problem: The tax benefit that an individual receives from making contributions to the account is also dependent on income. The incentive to save created by a tax shelter is weakest, ironically, among Americans who struggle most to save any of their paycheck.

Moreover, the annual insurance deductibles—which by law must be $1,000 or more—may be a prohibitively high hurdle for many Americans. A recent article in *The National Journal* reported that community health centers are seeing an influx of clients who have exhausted the amount in their accounts, but have not reached the levels needed for their high-deductible coverage to kick in. They are showing up at community clinics in need of care, essentially uninsured.

HSAs could have a particularly injurious impact on the use of preventive care, such as routine gynecologic care and family planning services. Although the law allows insurers to exempt preventive care from deductibles, and therefore make this care eligible for coverage even before a deductible is reached, insurers are not required to do so. If preventive care is not excluded from the deductible, some hard-pressed families or individuals might be forced to forego it.

Health Care Tax Credits

A third commonly touted approach to health care reform is tax credits to encourage individuals and families to purchase health insurance by reducing the amount they owe in taxes. If the credit were "refundable"—as in a proposal offered by the Bush administration—an individual or family could receive this subsidy in the form of a tax refund, even if they owe no income taxes at all, as is the case for many low-income Americans. Unlike a tax deduction, a refundable tax credit would not favor the rich. In fact, many proposals would make the credit available only at lower incomes, gradually phasing out for middle-class Americans.

Variations on the basic concept of health care tax credits have been proposed by policymakers, advocates and analysts of many political stripes, including the administration. In fact, a tax credit was created by Congress in 2002 for a very limited population—mostly workers displaced by international trade. Proponents of health care tax credits typically say that they would help Americans who do not have coverage through the workplace—particularly those who are unemployed, or who are not offered or cannot afford insurance at their job or through a family member's job.

Opponents of the approach, including analysts at the Urban Institute, cite several potential pitfalls. First, they say that under most of the proposals, families could use the tax credit only in a few, limited insurance markets. One option would be for individuals to purchase coverage through membership organizations or other groups. Although supporters believe that in time the tax credit itself would help establish these markets, currently they are virtually nonexistent.

For now, the only real option would be to enroll in HSAs or to purchase individual coverage. Nongroup plans traditionally have been less comprehensive than employment-based coverage. In an ironic twist for policymakers who fancy themselves "profamily," nongroup plans are exempt from the federal Pregnancy Discrimination Act, which requires coverage of maternity care in most group plans. One recent study found that maternity coverage is prohibitively expensive, severely limited or entirely absent from nongroup plans.

Moreover, nongroup coverage is generally much more expensive than equivalent employment-based coverage. Without a group over which the risks can be spread, insurers attempt to adjust their prices according to how much care they expect an individual enrollee to use.

This can quickly drive up premiums. In one proposal, the Bush administration set the credit at $1,000 for an individual and $3,000 for a two-parent family of four, well below the typical cost of nongroup plans. The problem is particularly acute for high-risk individuals, who could face prohibitive costs or problematic restrictions. This leads to questions about the ability of low-income families, or those with high-risk members, to afford comprehensive coverage. Would they forego coverage altogether, or perhaps settle for less expensive but limited coverage without the protections they need?

Reducing the Number of Uninsured?

Reducing the number of Americans lacking insurance coverage is a goal that has eluded policymakers for more than half a century. This failure has enormous consequences for the 13 million uninsured women of reproductive age—or one-third of all uninsured Americans. Whereas two in 10 women in that age-bracket are uninsured, the proportion doubles for those who are poor (see chart). Private insurance covers relatively few poor women—only 20%—because they have little access to affordable insurance through the workplace. And, despite its size, Medicaid cannot completely fill the gap, in large part because adult women are rarely eligible unless they are pregnant or parenting.

During President Bush's reelection campaign, the White House released predictions that his health care proposals would lead to "more than 11 million and as many as 17.5 million newly insured Americans." Yet, independent analysts looking at these proposals have reached strikingly different conclusions.

An analysis by the nonpartisan Congressional Budget Office (CBO) finds two likely results of the AHP approach. First, employers with healthier workforces would be more likely than others to move into these plans, leaving the traditional market with a higher concentration of less healthy groups, who would end up paying higher premiums. Second, the analysis finds that almost all of the 4.6 million individuals likely to be covered under AHPs would be "transfers" from traditional coverage; these individuals would likely have less comprehensive coverage than before, because they would not be covered by state mandated-benefit laws. CBO estimates that AHPs would reduce the number of uninsured Americans by a negligible 330,000 nationwide.

A 2004 analysis by Jonathan Gruber, a highly regarded health economist at the Massachusetts Institute of Technology, came to similar conclusions about the administration's plans to create tax credits and boost HSAs. He finds that both options would be used predominantly by people who are already insured. Moreover, whatever gain in coverage that would be reaped would be offset by the loss due to employers canceling insurance on the assumption that the availability of the new subsidies makes employment-based coverage unnecessary. Overall, Gruber estimates that one of the tax credit proposals would be used by 10 million people, but would only reduce the number of uninsured Americans by 1.8 million; the HSA proposal could in fact increase the number of Americans lacking health insurance by about 350,000.

In addition, groups such as the Center on Budget and Policy Priorities worry that tax credits and other proposals would similarly encourage states to scale back eligibility for Medicaid and the State Children's Health Insurance Program on the assumption that the new programs would provide a better alternative for low-income Americans. States would be wrong in that assumption, because the private plans Americans could buy on their own—if they could find anything at all—would be less affordable and provide fewer benefits than public programs. This is doubly the case when it comes to family planning services, because Medicaid includes several key requirements to bolster enrollees' access to those services. In addition, the billions of dollars the administration plans to spend on its health care initiatives might be one more reason to propose cutting Medicaid and other public programs (see related article, page 4).

In short, none of the approaches advanced by conservatives are likely to do much, if anything, to address the problem of the uninsured. And, in reality, reducing the number of uninsured Americans may not be their primary goal. Instead, these proposals fit into a larger attempt to bring free-market principles to bear in restructuring the private health insurance market for the so-called "ownership society." President Bush himself articulated this goal in late January when he described HSAs as an attempt at "empowering people to make decisions for themselves, owning their own health care plan, and at the same time bringing some demand control into the cost of health care."

Unfortunately, this route has enormous risks for low-income individuals and families, and especially for those needing preventive care. In transferring "ownership," these proposals would transfer much of the risk of needing expensive care from employers and insurers to individuals and families. Although the more affluent might be able to absorb that risk and still obtain the care they need, the same might not be true for the less affluent, who might struggle to save enough money for emergencies and quickly find themselves forced to forgo care they see as less immediately needed. Preventive services, such as many reproductive health care services, might be particularly likely to be foregone, to the detriment of individuals, families and the public health.