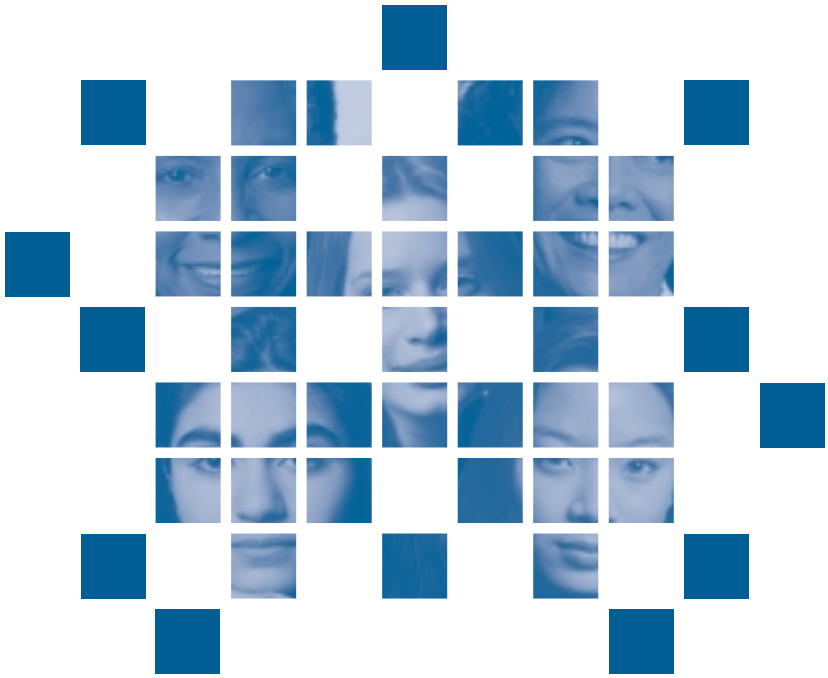

CHAPTER III

DESCRIPTION OF THE REPORT CARD INDICATORS

This chapter contains a description of the status and policy indicators used in the *Report Card*. These indicators measure women's access to health care services, the degree to which they receive preventive health care and engage in health-promoting activities, the occurrence of key women's health conditions, and the extent to which the communities in which women live enhance their health and well-being.

Women's Access to Health Care Services

The status indicators in this section reflect women's access to needed health care services. The policy indicators reflect whether a state has public policies and programs to provide insurance coverage, and whether it supports programs and services that remove barriers to health care.

Eligibility and Outreach for Publicly Funded Health Insurance

The *Report Card* identifies the number of women who need insurance and state policies to cover more people through publicly funded health insurance, including: Medicaid income eligibility requirements; Medicaid non-income eligibility requirements and outreach efforts; and other state-supported publicly funded health insurance programs.

STATUS INDICATOR: What percentage of women do not have health insurance?[1]

Without health insurance, most women cannot obtain appropriate health care. Although the lack of health insurance is a significant problem for both men and women, women face special challenges. A 2001 report by The Commonwealth Fund reveals that the number of women nationally who do not have insurance has grown three times faster than the number of men without health insurance over the past five years.[2] The report also finds that women need and use more health care services than men do, that uninsured women are more likely than are uninsured men to have difficulty obtaining health care services, and that women age 55 to 65 are more likely to be uninsured than are men in the same age group.[3] The *Report Card's* benchmark is the Healthy People 2010 benchmark of 100 percent coverage for all people (when applied to women).[4] No state meets the benchmark and therefore no state receives an "S". There are 11 states that are within ten percent of the benchmark and receive a "U": of these, seven states (CT, DE, HI, MA, MN, RI, WI) also received a "U" last year;

and four (IA, MI, PA, VT) improved from an "F". Thirty-nine states and the District of Columbia miss the benchmark by more than ten percent and receive an "F": of these, 38 states (AL, AK, AZ, AR, CA, CO, FL, GA, ID, IL, IN, KS, KY, LA, ME, MD, MS, MO, MT, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, SC, SD, TN, TX, UT, VA, WA, WV, WY) and the District of Columbia also received an "F" last year; and one state (NE) dropped from a "U." The nation receives an "F", as it did last year.

Policy Indicator: Has the state taken strong steps to expand Medicaid income eligibility?

Medicaid is a critical source of insurance for women: 16 percent of all women are Medicaid recipients.[5] While federal law requires states to cover specific categories of low-income adults, states may expand the pool of people covered by Medicaid, particularly by raising the income level at which people are eligible.[6] If Medicaid covered all individuals whose incomes are up to and including 200 percent of the federal poverty level (FPL), it is estimated that the number of uninsured would be halved.[7] The components of this indicator reflect state efforts to increase Medicaid participation by increasing the income eligibility levels for (a) pregnant women, (b) single parents and (c) the aged and disabled. Only the District of Columbia has all three policies. Fourteen states (AK, AZ, CA, HI, IL, ME, MA, MN, NJ, NY, RI, VT, WA, WI) have a limited composite policy because they have made substantial efforts to reach those income eligibility levels for all three groups. Thirty-one states (CO, CT, DE, FL, GA, ID, IN, IA, KS, KY, MD, MI, MS, MO, NE, NV, NH, NM, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, WV, WY) have not consistently raised the level in each category and therefore have a weak composite policy. Five states (AL, AR, LA, MT, VA) do not have any of the policies because they have not raised income eligibility levels above the federal minimum at all.

(a) Does the state Medicaid program cover pregnant women with incomes at or above 200 percent of FPL?[8] Expanded Medicaid coverage has contributed to the nationwide increase in women receiving prenatal care in the first trimester.[9] States have the policy when they raise the Medicaid qualifying income level for pregnant women to or above 200 percent of FPL. States have a limited policy when they raise the eligibility levels from above 133 percent up to and including 185 percent of FPL (which had been the upper ceiling for federal matching funds).[10] States are considered to have no policy if they do not raise the income eligibility levels above 133 percent. Thirteen states and the District of Columbia have the policy: of these, nine (AK, CA, GA, IL, MD, MA, MN, RI, VT) also had the policy in last year's *Report Card*; and four (DE, IA, ME, NY) and the District of Columbia improved from a limited policy. There are 25 states that have a limited policy: of these, 24 (AZ, CT, FL, HI, IN, KS, KY, MI, MS, MO, NE, NH, NJ, NM, NC, OK, OR, PA, SC, TN, TX, WA, WV, WI) also had a limited policy in last year's *Report Card*; and one (OH) improved from no policy.[11] There are 12 states that do not have the policy: of these, all 12 (AL, AR, CO, ID, LA, MT, NV, ND, SD, UT, VA, WY) did not have the policy in last year's *Report Card*.[12]

(b) Does the state Medicaid program cover single parents with incomes at or above 200 percent of FPL?[13] Because nearly half of all working poor families are uninsured, with a large percentage headed by women, expanding Medicaid coverage by raising eligible income levels is critical to ensure that these low-income families have access to health care services.[14] States have the *Report Card* policy when they expand their Medicaid income eligibility requirements to cover single parents with incomes at or above 200 percent. States have a limited policy when they expand the Medicaid eligibility over 74 percent of FPL but below 200 percent of FPL. States are considered to have no policy if they fail to raise these requirements beyond 74 percent of FPL.[15] Two states and the District of Columbia have the policy: of these, one (MN) and the District of Columbia also had the policy in last year's *Report Card*; and one (NJ) improved from no policy. There are 20 states that have a limited policy: of these, 17 (AK, CA, DE, HI, IA, ME, MA, MO, NV, ND, OH, OR, RI, TN, VT, WA, WI) also had a limited policy in last year's *Report Card*; and three (AZ, KY, NY) improved from no policy.[16] There are 28 states that do not have the policy: of these, all 28 (AL, AR, CO, CT, FL, GA, ID, IL, IN, KS, LA, MD, MI, MS, MT, NE, NH, NM, NC, OK, PA, SC, SD, TX, UT, VA, WV, WY) also did not have the policy in last year's *Report Card*.

(c) Does the state Medicaid program cover the "aged and disabled" with incomes at or above 100 percent of FPL?[17] Although most women age 65 and over and many disabled women have health insurance through Medicare, Medicaid is a crucial additional source of coverage for six million low-income elderly Medicare beneficiaries and for 6.8 million disabled individuals.[18] States demonstrate a commitment to the aged and disabled when they expand income eligibility to or above 100 percent of FPL.[19] States have a limited policy when they expand the eligibility level below 100 percent FPL, but more than the federal minimum of 74 percent. States are considered not to have a policy if they are either below or do not expand their eligibilities beyond the standard federal minimum policy.[20] Nineteen states and the District of Columbia have the policy: of these, 13 (AK, HI, ME, MA, MI, MS, NE, NJ, NC, ND, PA, SC, UT) and the District of Columbia also had the policy in last year's *Report Card*; four (CA, OK, RI, SD) improved from a limited policy; one (AZ) improved from no policy; and one (IL) did not have data available in the 2000 *Report Card*.[21] There are 12 states that have a limited policy: of these, all 12 (CO, CT, FL, ID, MN, NV, NH, NY, VT, WA, WI, WY) also had a limited policy in last year's *Report Card*.[22] There are 19 states that do not have the policy: of these, all 19 (AL, AR, DE, GA, IN, IA, KS, KY, LA, MD, MO, MT, NM, OH, OR, TN, TX, VA, WV) also did not have the policy in last year's *Report Card*.

Policy Indicator: How much has the state expanded Medicaid non-income eligibility requirements and Medicaid outreach efforts?

States can expand the pool of women insured by Medicaid by changing non-income-related eligibility requirements and by investing in efforts to reach out to people eligible for Medicaid

who are not currently participating in the program. Expanded outreach is especially important because a recent significant drop in the number of Medicaid enrollees has been attributed to the lack of knowledge by many that they are eligible for Medicaid despite the ineligibility for cash assistance due to changes in the welfare laws.[23] This policy indicator includes four key options for expanding Medicaid coverage: (a) dropping restrictions for two-parent working families; (b) providing presumptive eligibility for pregnant women; (c) allowing parents to use the same simplified application available to their children and to submit the application by mail; and (d) eliminating the assets test for parents. Only three states (DE, MA, MO) and the District of Columbia have all four of the policies. Eight states (IL, MI, MN, NM, OK, PA, RI, VT) have three of the four policies and therefore have a limited composite policy. Thirty six states (AL, AK, AZ, AR, CA, CO, CT, FL, GA, HI, ID, IN, IA, KS, LA, ME, MD, MS, MT, NE, NV, NH, NJ, NY, NC, OH, OR, SC, SD, TN, TX, UT, VA, WA, WI, WY) have a weak composite policy because they have only one or two of the policies. Three states (KY, ND, WV) do not have any of the policies.

(a) Has the state dropped a Medicaid 100-hour work disqualifier for two-parent families?[24] The federal government will cover some of the costs that states incur if they drop a "100-hour" rule under which two-parent families lose coverage if the principal wage earner works more than 100 hours per month.[25] Many states have dropped the Medicaid 100-hour work disqualifier for two-parent families. Thirty-eight states and the District of Columbia have this policy of dropping the rule: of these, 34 (AL, AK, AZ, CO, CT, DE, GA, HI, ID, IL, IN, IA, KS, MD, MA, MI, MN, MS, MO, MT, NV, NJ, NM, NY, NC, OH, OR, RI, SC, SD, TX, VT, VA, WA) and the District of Columbia had the policy in last year's *Report Card*; four (FL, OK, PA, WY) improved from having a harmful policy.[26] Twelve states have the harmful 100-hour policy: of these, all 12 (AR, CA, KY, LA, ME, NE, NH, ND, TN, UT, WV, WI) had a harmful policy last year.[27]

(b) Does the state provide presumptive Medicaid eligibility for pregnant women?[28] Given the importance of prenatal care early in pregnancy, states advance women's health when they adopt a policy that makes a pregnant woman "presumptively" eligible for Medicaid once she submits preliminary income information to Medicaid. Presumptive eligibility allows the woman to receive Medicaid coverage as early as possible while her application is being approved.[29] Twenty-eight states and the District of Columbia have this policy: of these, 25 (AR, CA, CO, DE, FL, GA, ID, IL, IA, LA, ME, MA, MO, NE, NH, NJ, NM, NY, NC, OK, PA, TN, UT, WI, WY) and the District of Columbia had the policy in last year's *Report Card*; three (MI, MT, TX) improved from no policy. Twenty-two states have no policy: of these, 20 (AL, AK, AZ, HI, IN, KS, KY, MD, MN, MS, NV, ND, OH, OR, RI, SD, VT, VA, WA, WV) also did not have the policy last year; two (CT, SC) dropped from having the policy.

(c) Does the state allow parents and children to apply for Medicaid using the same simplified mail-in application?[30] Under current Medicaid laws, states have significant flexibility in designing their Medicaid application/enrollment process and can make it easier for parents to enroll in Medicaid by allowing them to apply jointly with their children, using a simplified mail-in application.[31] The data from last year's *Report Card* have not been updated. Ten states (DE, MA, MN, MO, OR, RI, SC, SD, UT, VT) and the District of Columbia have the policy, and 40 states (AL, AK, AZ, AR, CA, CO, CT, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MS, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, PA, TN, TX, VA, WA, WV, WI, WY) do not.[32]

(d) Has the state dropped the assets test for parents, thereby both facilitating the application process and increasing the pool of eligible people?[33] Welfare reform gave states the option to disregard parents' ownership of basic assets (e.g., a family car, home or savings account) when determining their eligibility for Medicaid.[34] Eliminating this "assets test" simplifies the application process, streamlines and reduces administrative costs, and increases the pool of eligible people.[35] Fourteen states and the District of Columbia have the policy: of these, 12 (DE, IL, MA, MN, MS, MO, OH, OK, PA, RI, VT, WI) and the District of Columbia had the policy in last year's *Report Card*; two (MI, NM) improved from no policy. Thirty-six states do not have the policy: of these, all 36 (AL, AK, AZ, AR, CA, CO, CT, FL, GA, HI, ID, IN, IA, KS, KY, LA, ME, MD, MT, NE, NV, NH, NJ, NY, NC, ND, OR, SC, SD, TN, TX, UT, VA, WA, WV, WY) also did not have the policy in last year's *Report Card*.

Policy Indicator: Does the state provide health care coverage for low-income adults not otherwise eligible for publicly funded health insurance?[36]

States can adopt many policies to help low-income women move out of the ranks of the uninsured, including programs that provide publicly funded health insurance to otherwise uninsured, low-income adults, regardless of their parental status, age or disability. States that have the policy provide comprehensive health coverage (with covered services similar to Medicaid) to otherwise uninsured adults whose incomes are at or above 100 percent of FPL.[37] States have a limited policy if they have similar programs but they set the income eligibility requirement below 100 percent of FPL, cap enrollment, or only provide coverage in limited portions of the state. Eight states have the policy: of these, seven (DE, MA, MN, NY, OR, VT, WA) had the policy in last year's *Report Card*. One state (AZ) improved from a limited policy. There are three states that have a limited policy: of these, all three (CA, HI, TN) also had a limited policy last year. Thirty-nine states and the District of Columbia do not have a policy: of these, all 39 (AL, AK, AR, CO, CT, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MS, MO, MT, NE, NV, NH, NJ, NM, NC, ND, OH, OK, PA, RI, SC, SD, TX, UT, VA, WV, WI, WY) and the District of Columbia also had a weak policy or did not have a policy in last year's *Report Card*.

Overcoming Barriers to Health Care Beyond Insurance Coverage

Even women with health insurance face many barriers to health care. The status indicators that follow examine the availability of health care services. The policy indicators reflect state efforts to remove barriers caused by the lack of health care providers, the inability to leave work to address medical needs, limits on patients' rights under their managed care programs and limited English proficiency.

STATUS INDICATOR: What percentage of people live in "medically underserved areas"?[38]

In the United States, nearly one in ten people lives in a "medically underserved area" ("MUA"), with reduced access to primary care physicians.[39] The lack of accessible health care services is particularly acute for poor and low-income people, who do not have the financial resources to travel to find health care.[40] Although state data regarding the percentage of women who live in underserved areas are not available, the state data for men and women overall are a useful proxy to assess women's access to primary care. No benchmark is available for this indicator, so it is ranked, not graded. Hawaii ranked first (2.8 percent) and Mississippi ranked last (24.4 percent). The national average is 9.5 percent. In the 2000 *Report Card*, Maryland ranked first (2.2 percent), Louisiana ranked last (24.0 percent) and the national average was 9.6 percent.

POLICY INDICATOR: Safety net services: does the state fund the operation of comprehensive primary medical care practice programs for the medically underserved?[41]

Although the federal government supports "safety net" providers of medical services designed to help low-income people who might otherwise fall through cracks in the system, current federal efforts only reach about ten percent of the uninsured and less than 25 percent of the underinsured.[42] Some states have attempted to provide a safety net by funding the operation of "comprehensive primary medical care practice" programs that provide preventive and diagnostic services and hospital referrals on a 24-hour basis to low-income individuals.[43] A state's financial support for the operation of primary medical care programs reflects its commitment to providing the uninsured and medically underserved with access to health care services. Twenty-six states have the policy: of these, 14 (AZ, CT, HI, MA, MI, MN, NH, NJ, NM, NY, RI, TX, WA, WV) also had the policy in last year's *Report Card*; 12 (AK, AR, CO, FL, IL, IN, MS, MO, OK, PA, UT, WI) improved from no policy. Twenty-four states and the District of Columbia do not have the policy: of these, 19 (AL, DE, ID, IA, KS, KY, LA, ME, MT, NE, NV, ND, OH, OR, SD, TN, VT, VA, WY) and the District of Columbia also did not have the policy in last year's *Report Card*; and five (CA, GA, MD, NC, SC) dropped from having the policy.

POLICY INDICATOR: Is support for family and medical leave available?

Many women facing a serious health condition of their own or caring for a family member cannot afford to take needed time away from work. Because women disproportionately bear the responsibility for family care giving, many endanger their own health by struggling to meet the demands of both work and family care. While providing unpaid family and medical leave was the first step in helping Americans balance work and family responsibilities, paid leave makes such leave more affordable and therefore available for lower-income families. The U.S. Department of Labor in June 2000 finalized regulations to permit states to offer unemployment benefits to new parents who require time off from work.[44] It is too early to assess how states are taking advantage of the new option to assist in providing paid leave, but it is important to follow in the future. States can help women facing family and medical responsibilities by adopting the policies reflected in (a) the family and medical leave expansions and (b) the paid temporary disability insurance requirements in this composite indicator. Three states (CA, HI, RI) have the composite policy because they both expand family and medical leave and provide paid temporary disability insurance. Sixteen states (CT, IL, IA, KY, LA, ME, MA, MN, MT, NV, NH, NJ, NY, OR, TN, VT) and the District of Columbia have one of the two policies and therefore have a limited composite policy. Thirty-one states (AL, AK, AZ, AR, CO, DE, FL, GA, ID, IN, KS, MD, MI, MS, MO, NE, NM, NC, ND, OH, OK, PA, SC, SD, TX, UT, VA, WA, WV, WI, WY) do not have either policy.

(a) Does the state have a family and medical leave law that offers protections in addition to those provided by the federal law?[45]

Although the federal Family and Medical Leave Act (FMLA) requires larger employers to allow workers to take unpaid leave to recover from their own illnesses or to care for certain family members in certain circumstances, almost half of the private workforce (41 million people) is not covered by the FMLA.[46] States can expand family and medical leave coverage by covering more people and/or by providing more generous family and medical leave benefits than the federal law.[47] The data from last year's *Report Card* have not been updated. Seventeen states (CA, CT, HI, IL, IA, KY, LA, ME, MA, MN, MT, NV, NH, OR, RI, TN, VT) and the District of Columbia have the policy and the remaining 33 states (AL, AK, AZ, AR, CO, DE, FL, GA, ID, IN, KS, MD, MI, MS, MO, NE, NJ, NM, NY, NC, ND, OH, OK, PA, SC, SD, TX, UT, VA, WA, WV, WI, WY) do not have the policy.

(b) Does the state provide temporary disability insurance?[48] Many women cannot afford to take unpaid family or medical leave (as provided by federal and state family and medical leave laws).[49] States can assist these women by providing some payment during family and medical leave periods through temporary disability insurance (TDI) laws (usually provided through expansions of unemployment or disability insurance). Although limited, these laws provide partial wage replacement for employees who are temporarily disabled for non-work related reasons and represent a first step toward making personal medical leave more affordable.[50] There are no new states that adopted this policy since last year's *Report Card*. Five states (CA, HI, NJ, NY, RI) have the policy.[51] The remaining 45 states (AL, AK, AZ, AR, CO, CT, DE, FL,

GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY) and the District of Columbia do not have the policy.

Policy Indicator: Does the state provide managed care patient protections?

The Commonwealth Fund Survey of the Health of American Women found that in 1998, three-quarters of insured women were enrolled in some form of managed care plan.[52] Some information suggests that managed care plans are doing at least as good a job with preventive care for women as fee-for-service plans, and possibly better.[53] Concerns have arisen, however, about managed care practices that may impede access to needed treatment, especially higher cost care, and to fair grievance mechanisms, particularly for low-income and less educated women. Although states have adopted many different protections, this indicator includes four components that reflect policies of particular import to women: (a) direct access to broad obstetrical-gynecological and health maintenance services; (b) "continuity of care" provisions; (c) coverage for participation in clinical trials; and (d) the right to external review of complaints. Four states (DE, ME, VT, VA) have all four of the policies. Twenty-four states (AZ, CA, CO, CT, FL, KS, KY, LA, MD, MA, MI, MN, MO, NH, NJ, NM, NY, PA, RI, SC, TN, TX, WA, WI) and the District of Columbia have adopted substantial but not complete aspects of these policies and therefore are considered to have a limited composite policy of managed care patient protection. Nineteen states (AL, AK, AR, GA, HI, ID, IL, IN, IA, MS, MT, NV, NC, OH, OK, OR, SD, UT, WV) have either adopted fewer policies or weaker versions of the policies and therefore are considered to have a weak composite policy. Three states (NE, ND, WY) have none of these policies.

(a) Does the state require that managed care programs allow women to have direct access to broad reproductive, gynecologic and health maintenance services?[54] Direct access to broad reproductive, gynecologic and health maintenance services allows women, if they choose, to obtain access to reproductive and related health care without having to obtain a referral first.[55] While it is preferable for states to provide direct access to physicians, midwives, nurse practitioners, nurses and other trained providers of these services, most states have focused on women's access to physicians. Thirty-nine states and the District of Columbia have the policy: of these, 35 (AL, AR, CA, CO, CT, DE, FL, GA, ID, IL, LA, ME, MD, MI, MN, MS, MO, MT, NV, NH, NM, NY, NC, OH, OR, PA, RI, SC, TN, TX, UT, VT, VA, WA, WV) and the District of Columbia had the policy in last year's *Report Card*; and four (KS, KY, MA, WI) improved from no policy. There are 11 states that do not have a policy: of these, all 11 (AK, AZ, HI, IN, IA, NE, NJ, ND, OK, SD, WY) also did not have the policy last year.

(b) Does the state have "continuity of care" provisions?[56] Continuity of care provisions protect patients from disruptions in care because of a change in plan or a change in a provider's network status. These provisions are particularly important for pregnant women, patients with chronic or long-term illnesses and patients with terminal illnesses. States have the policy when they require plans to cover continued care from the provider: (a) for at least 60 days; (b) if the patient is pregnant and has begun prenatal care with the provider; and (c) if the patient faces any condition so severe that the treatment is medically necessary.[57] States have a limited policy when they have at least one or two of these continuity of care provisions. Sixteen states have the policy: of these, 14 (AR, CA, DE, FL, MN, MO, NJ, NY, PA, SD, TN, VT, VA, WI) and the District of Columbia had the policy in last year's *Report Card*; two (AK, ME) improved from no policy.[58] There are 17 states that have a limited policy: of these, ten (CO, IL, IN, IA, KS, MD, OK, OR, SC, TX) also had a limited policy last year; seven (AZ, KY, MA, MI, NH, WA, WV) improved from no policy.[59] There are 17 states that do not have the policy: of these, all 17 (AL, CT, GA, HI, ID, LA, MS, MT, NE, NV, NM, NC, ND, OH, RI, UT, WY) also did not have the policy last year.

(c) Does the state require managed care programs to cover clinical trials for adults?[60] Access to clinical trials can be crucial in defining and treating life-threatening illnesses, especially when experimental approaches are the only treatment available. Some states have a strong clinical trial policy because they require managed care plans to pay the routine costs associated with these trials for adult patients. Eleven states have the policy: of these, four (LA, MD, RI, VA) had the policy in last year's *Report Card*; seven (AZ, CT, DE, ME, NH, NM, VT) improved from no policy. One state (IL) requires insurers to *offer* coverage and therefore has a weak policy.[61] There are 38 states and the District of Columbia that do not have the policy: of these, all 38 (AL, AK, AR, CA, CO, FL, GA, HI, ID, IN, IA, KS, KY, MA, MI, MN, MS, MO, MT, NE, NV, NJ, NY, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, WA, WV, WI, WY) and the District of Columbia also did not have the policy last year.[62]

(d) Does the state require managed care programs to provide patients with a right to external review of the managed care company's decisions?[63] A strong grievance and appeals process that includes a right to an external review (i.e., a review by an independent party) allows patients to challenge denial of care claims and to address their own health needs. Some states require managed care organizations to have an external review procedure. Thirty-seven states and the District of Columbia have the policy: of these, 26 (CA, CO, CT, FL, GA, HI, IN, IA, KS, LA, MD, MI, MN, MO, MT, NJ, NM, NY, OH, OK, PA, RI, TN, TX, VT, VA) and the District of Columbia had the policy in last year's *Report Card*; 11 (AL, AK, AZ, DE, KY, ME, MA, NH, SC, WA, WI) improved from no policy. There are 13 states that do not have the policy: of these, 12 (AR, ID, MS, NE, NV, NC, ND, OR, SD, UT, WV, WY) also did not have the policy last year; one (IL) dropped from having a policy.[64]

POLICY INDICATOR: Does the state have comprehensive requirements for the provision of appropriate interpretation and translation services to patients with limited English proficiency?[65]

Language barriers can inhibit a health care provider's ability to diagnose and treat patients with limited English proficiency – a barrier to health care that affects millions of people who do not have the ability to proficiently speak, read, write and understand the English language.[66] The data from last year's *Report Card* have not been updated. Based on that data, only four states (CA, IL, MA, NY) have a comprehensive legal requirement to address the language needs of those seeking health care. Laws and/or regulations in 23 states (AK, AZ, AR, CO, CT, DE, FL, HI, KS, LA, ME, MI, MN, NV, NJ, NC, OH, PA, RI, TX, UT, VT, WA) and the District of Columbia have limited references to language barriers. The laws and regulations in the remaining 23 states (AL, GA, ID, IN, IA, KY, MD, MS, MO, MT, NE, NH, NM, ND, OK, OR, SC, SD, TN, VA, WV, WI, WY) do not address at all the barriers to health care facing individuals with limited English proficiency.

Methods to Improve Access to Specific Health Care Services

States can improve women's access to health care by improving access to specific services important to them. The status indicators that follow reflect access to prenatal care and abortion services, essential services for women that are also indicative of women's access to general health care services. The policy indicators address: pharmaceuticals; long-term care; mental health care services; diabetes supplies and education; services related to mastectomies; family planning services; maternity hospital stays and infertility treatment; abortion services; and services for women who are victims of violence.

STATUS INDICATOR: What percentage of pregnant women receive prenatal care in the first trimester?[67]

Women who have prenatal care beginning in their first trimester of pregnancy (i.e., within the first 12 weeks) tend to stay healthier and have healthier babies.[68] The *Report Card's* benchmark is the Healthy People 2000 goal that at least 90 percent of all pregnant women receive prenatal care in the first trimester of pregnancy.[69] Two states meet the benchmark and receive an "S": both of these states (NH, RI) improved from a "U" in last year's *Report Card*. There are 36 states that are within ten percent of the benchmark and receive a "U": of these, 33 states (AL, CO, CT, DE, FL, GA, HI, IL, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NE, NJ, NC, ND, OH, PA, SD, TN, VT, VA, WA, WV, WI, WY) also received a "U" last year; and three states (CA, MS, NY) improved from an "F". Twelve states and the District of Columbia miss the benchmark by more than ten percent and receive an "F": of these, 11 states (AK, AZ, AR, ID, IN, NV, NM, OK, OR, SC, TX) and the District of Columbia also received an "F" last year; and one state (UT) dropped from a "U". The nation receives a "U", as it did last year.

STATUS INDICATOR: What percentage of women live in a county without an abortion provider? [70]

The number of abortion providers nationwide has declined by 30 percent since 1982, and the lack of access to abortion providers is particularly severe for women living in rural communities.[71] The absence of health care providers trained and available to provide abortion services can endanger women's lives and health. Nationally, almost one-third of all women reside in a county with no abortion provider.[72] Although other types of providers may perform abortion services, this procedure should be as available to women as access to obstetrical-gynecological services. Therefore, the states are graded based on a comparison between the percentage of women living in a county without an abortion provider and the percentage of women who live in a county without an office based obstetrician-gynecologist.[73] The data from last year's *Report Card* have not been updated. In two states (HI, MA) and the District of Columbia, the same percentage of women live in a county without an abortion provider as live in a county without an obstetrician-gynecologist; they receive an "S". The remaining 48 states (AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY) are not within ten percent of the benchmark; these states receive an "F". The nation also receives an "F".

POLICY INDICATOR: How well does the state assist women in gaining access to prescription drugs?

The high cost of prescription drugs has become a barrier to health care in the United States, creating financial hardship for many, but particularly for older women.[74] In 1999, spending for prescription drugs accounted for the largest portion of individual out-of-pocket health care spending after premium payments.[75] Medicare does not cover most pharmaceuticals and almost half of Medicare beneficiaries do not have continuous drug coverage from some other source throughout the year.[76] States can help low-income, elderly and disabled patients afford prescription drugs through the policies included in this indicator: (a) Medicaid coverage for an unlimited number of prescriptions; (b) elimination of Medicaid prescription co-payments; (c) non-Medicaid state pharmaceutical assistance programs; and (d) high eligibility levels in their AIDS Drug Assistance Program (ADAP) (specifically targeted to people with AIDS/HIV). States have the composite policy when they have all four pharmaceutical measures. States have a limited composite policy when they have two or three policies that have a significant effect on the availability of pharmaceuticals. States have a weak composite policy when they have only one of the four policies, and have other policies so limited that their effect is minimal. Only one state (NJ) has all four of these policies. Twenty-seven states (AZ, CT, DE, HI, ID, IL, IA, KS, KY, ME, MD, MA, MI, MN, MO, NV, NH, NM, NY, OH, OR, PA, RI, VT, WA, WI, WY) and the District of Columbia have a limited composite policy. Twenty-two states (AL, AK, AR, CA, CO, FL, GA, IN, LA, MS, MT, NE, NC, ND, OK, SC, SD, TN, TX, UT, VA, WV) have a weak composite policy. Every state has at least some policy.

(a) Does the state Medicaid drug benefit cover an unlimited number of prescriptions?[77] The Medicaid prescription drug benefit is the second most frequently used Medicaid benefit (second only to physician services).[78] Although states must comply with federal guidelines to receive matching funds, they have some flexibility in determining the scope of coverage, including whether to limit the number of prescriptions covered during a specific time period.[79] Research has shown that these restrictions significantly limit Medicaid beneficiaries' access to prescription drugs.[80] States have the policy when they do not restrict the number of prescriptions covered during a specified time period. States have a harmful policy when they impose restrictions on the number of prescriptions covered. Thirty-eight states and the District of the Columbia have the policy: of these, 36 (AL, AK, AZ, CO, CT, DE, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NE, NH, NJ, NM, NY, ND, OH, OR, PA, RI, SD, UT, VT, VA, WA) and the District of Columbia had the policy in last year's *Report Card*; two (WI, WY) improved from having a harmful policy. Twelve states have a harmful policy; of these, 11 (AR, CA, FL, GA, MS, NV, NC, OK, SC, TX, WV) had a harmful policy last year; and one state (TN) dropped from having the policy to adopting a harmful policy.

(b) Does the state Medicaid program cover prescriptions without a patient co-payment?[81] Like the restrictions on the number of prescriptions that can be filled, co-payment requirements also seriously limit Medicaid patients' access to prescription drugs, because even a minimal out-of-pocket cost may be too expensive for low-income women and may prevent them from buying prescriptions they need.[82] States have the policy when they provide Medicaid prescription coverage without requiring co-payments. States have a limited policy when they require co-payments of two dollars or less. States have a harmful policy when they require co-payments of more than two dollars. Nineteen states have the no co-payment policy: of these, 17 (CT, DE, FL, HI, ID, IL, KY, MN, NV, NJ, NM, ND, OH, OR, RI, TX, WA) had the policy in last year's *Report Card*; two states (AZ, TN) improved from a limited policy.[83] Twenty-five states and the District of Columbia have limited policies; all 25 (AK, CA, CO, GA, IA, KS, MD, MA, MI, MS, MO, MT, NE, NH, NY, NC, OK, PA, SC, SD, VT, VA, WV, WI, WY) and the District of Columbia had a limited policy last year. Six states have harmful policies: of these, five (AL, AR, IN, LA, ME) had harmful policies last year; one (UT) dropped from having a limited policy to having a harmful policy.

(c) Does the state have a broad, non-Medicaid pharmaceutical program?[84] State-sponsored "pharmacy assistance" programs help to ease the financial burden of buying prescription drugs for non-Medicaid-eligible, low-income people.[85] Eligibility varies by state, and is often restricted by income, and to those over age 65 and people with disabilities. Within each program, variations include the scope of medications covered, the amount of cost-sharing involved, and program structure.[86] There has been significant improvement in state non-Medicaid pharmaceutical programs since the 2000 *Report Card*. States have the policy if they have high income eligibility levels, cover most or all medications, and have small co-payments or limited cost-sharing. States have a limited policy if their income eligibility levels are not sufficiently high, if they place significant restrictions on the medications they cover or if they impose significant cost sharing. Five states have the policy: of these, two (NJ, PA) had the policy in last year's *Report Card*; three (ME, MA, NY) improved from having a limited policy. Twenty-six states and the District of Columbia have a limited policy: of these, 11 (CA, CT, DE, IL, MD, MI, MN, NV, RI, VT, WY) also had a limited policy last year; 15 (AZ, AR, FL, IN, IA, KS, MO, NH, NC, OR, SC, TX, WA, WV, WI) and the District of Columbia improved from having no policy.[87] Nineteen states have no policy: all of these states (AL, AK, CO, GA, HI, ID, KY, LA, MS, MT, NE, NM, ND, OH, OK, SD, TN, UT, VA) had no policy last year.

(d) Does the state cover pharmaceuticals for individuals with incomes at or above 400 percent of the federal poverty guidelines under the AIDS Drug Assistance Program? [88] State AIDS Drug Assistance Programs (ADAP) provide access to HIV/AIDS pharmaceuticals to low-income, uninsured and under-insured people living with HIV/AIDS who otherwise could not afford these drugs to improve the quality and length of their lives. There is a serious need for increased federal support due to the increasing number of people living with HIV. One major publication on ADAP programs reported that some states anticipate running out of funds before the end of the fiscal year; others have placed additional restrictions on their programs.[89] States have the policy if they allow people at 400 percent or higher of federal poverty guidelines to participate in the ADAP program. States have a limited policy if they allow people with incomes from 200 percent to 400 percent of the federal poverty guidelines to participate. States have a weak policy if they allow only individuals with incomes below 200 percent of the federal poverty guidelines to participate. Ten states have the policy: of these, nine (CA, HI, IL, MD, MS, NV, NJ, NY, RI) had the policy in last year's *Report Card*; one (MI) improved from a limited policy. Thirty-six states and the District of Columbia have a limited policy: of these, 34 (AL, AK, AZ, AR, CT, DE, FL, ID, IN, IA, KS, KY, LA, ME, MA, MN, MO, NE, NH, NM, OH, OR, PA, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY) and the District of Columbia had limited policies last year; two (GA, MT) improved from a weak policy.[90] Three other states (AZ, FL,VA) also increased their eligibility levels since last year's *Report Card*, but not enough to change their standing in the 2001 *Report Card*. All four states (CO, NC, ND, OK) with weak policies also had weak policies last year. Every state has at least some policy, as it did last year.

Policy Indicator: Does the state provide for access to quality long-term care services?

Women constitute the majority of long-term care recipients.[91] Approximately three out of four nursing home residents are women, and two out of three home care consumers are women.[92] There are many barriers to quality long-term care services, including cost. Medicare does not cover most long-term care services, and there are serious limitations on the coverage available

through private insurance or Medicaid.[93] This composite indicator includes several components that measure state commitment to affordable, quality long-term care: (a) paid ombudsman program staff; (b) "spousal impoverishment" Medicaid eligibility rules; and (c) Medicaid coverage for home and community-based care. Only six states (AK, GA, LA, ME, MS, WY) and the District of Columbia have the composite policy because they have the number of ombudsmen that meets an Institute of Medicine standard and have the highest spousal impoverishment eligibility requirements allowed by the federal government (the *Report Card* does not provide a state-by-state categorization for the third component of this indicator). There are five states (DE, MA, NM, SD, TX) that have an acceptable level of ombudsmen and have also moderately improved their spousal impoverishment eligibility requirements and therefore have a limited composite policy. Twenty-four states (AL, CA, CO, FL, HI, ID, IL, IA, KY, MN, MT, NV, NH, NY, ND, OH, OK, SC, TN, UT, VT, WA, WV, WI) have adopted one of the policies (sometimes in a weaker form) and therefore have a weak composite policy. The remaining 15 states (AZ, AR, CT, IN, KS, MD, MI, MO, NE, NJ, NC, OR, PA, RI, VA) do not have either policy.

(a) Does the state's long-term care ombudsman staffing level meet the Institute of Medicine's (IOM) minimum acceptable standards?[94] Residents in long-term care facilities often need an advocate to help them (or their families) address problems. The federal long-term care ombudsman program, administered and partially funded by the states, provides "ombudsmen" who act as advocates to help residents and their families obtain a better quality of life in long-term care settings.[95] In 1994, the IOM issued a landmark report that determined the minimum acceptable ratio of paid ombudsmen per long-term care facility beds to be one to 2,000.[96] In this year's *Report Card*, the average national ombudsman-to-bed ratio was one to 2,810, falling short of the IOM minimum standard by about one-third. Eighteen states and the District of Columbia have the policy: of these, 16 (AK, DE, GA, ID, ME, MA, MS, MT, NV, NM, OH, SD, UT, VT, WV, WY) and the District of Columbia had the policy in last year's *Report Card*; two (LA, NH) improved from no policy.[97] There are 32 states that do not have the policy: of these, 28 (AL, AZ, AR, CA, CT, FL, HI, IL, IN, IA, KS, MD, MI, MO, NE, NJ, NY, NC, ND, OK, OR, PA, RI, TN, TX, VA, WA, WI) also did not have the policy last year; four (CO, KY, MN, SC) dropped from having a policy last year.

(b) Has the state chosen the largest allowable protection for income and assets of the "community" spouses of nursing home residents under the Medicaid program?[98] To prevent the high cost of long-term care from impoverishing the spouses of nursing home residents, federal law now requires states to protect the assets and income of the non-institutionalized spouse ("community spouse") through a "resource allowance" and "income allowance."[99] In general, the couple's resource level determines whether the nursing home resident is eligible for Medicaid, while the couple's income level determines how much money (if any) the nursing home resident has to pay the nursing home each month.[100] States that have the highest resource and income allowances allowed by the federal government are considered to have the policy identified by the *Report Card*. Some states have a limited policy because they have chosen neither the highest level nor the lowest level allowed, and some states offer the lowest level permitted and are considered to have no policy. Twelve states and the District of Columbia have the policy: of these, ten (AK, CA, GA, HI, IL, IA, KY, LA, MS, ND) and the District of Columbia had the policy in last year's *Report Card*; and two (ME, WY) improved from a limited policy. Sixteen states have a limited policy: of these, all 16 (AL, CO, DE, FL, MA, MN, NM, NY, OK, SC, SD, TX, UT, VT, WA, WI) had a limited policy last year. There are 22 states that have no policy: of these, 21 (AZ, AR, CT, IN, KS, MD, MI, MO, MT, NE, NV, NH, NJ, NC, OH, OR, PA, RI, TN, VA, WV) also did not have a policy last year; and one (ID) dropped from having a limited policy.

(c) How many adults per 1,000 receive Medicaid Home and Community-Based Services (HCBS)?[101] For older and disabled women, home and community-based long-term care can offer greater independence and more familiar surroundings than living in a nursing home.[102] Most state-supported HCBS are funded through various state options in the Medicaid program.[103] Because of limited data on the scope of services offered by states, the *Report Card* measures the number of adults who receive HCBS Medicaid benefits as a proxy. These data are not analyzed by sex, so the number of total men and women served in each state is provided. The states range from 10.95 HCBS recipients per 1,000 adults in Arkansas to .83 HCBS recipients per 1,000 adults in Tennessee. In the 2000 *Report Card*, the states ranged from 11.09 HCBS recipients per 1,000 adults in Oregon to .07 HCBS recipients per 1,000 adults in Tennessee. The national average is 4.28 per 1,000; it was 3.30 in the 2000 *Report Card*.

Policy Indicator: Has the state enacted mental health parity legislation?

Approximately one in five Americans suffers from a mental disorder in any given year and this percentage may increase in the wake of the September 11, 2001 tragedies, yet many insurers fail to cover mental health services on the same basis as physical health services.[104] In fact, two in three adults with a diagnosed mental disorder do not receive treatment.[105] One important way for states to increase access to mental health care services, in addition to Medicaid coverage, is to enact mental health parity legislation that requires private insurers to cover mental health disorders on the same basis as physical disorders.[106] This indicator is a composite of three mental health parity issues of particular importance to women. The *Report Card* reviews general mental health parity mandates for private insurers. The *Report Card* also reviews eating disorder parity mandates and depression parity mandates for private insurers. States that have the policy identified by the *Report Card* provide mental health parity protection that includes both eating disorders and depression. Only four states (CT, MD, MN, VT) have the composite policy. Six states (AR, CA, DE, IN, KY, LA) provide either near-comprehensive parity or

limited parity that covers eating disorders and depression and therefore have a limited composite policy. Twenty states (AZ, CO, HI, ME, MA, MO, MT, NE, NV, NH, NJ, NC, OK, RI, SC, SD, TN, TX, UT, VA) offer minimal mental health parity protections and therefore have a weak composite policy. Nineteen states (AL, AK, FL, GA, ID, IL, IA, KS, MI, MS, NY, ND, OH, OR, PA, WA, WV, WI, WY) and the District of Columbia do not have any mental health parity protections at all.[107]

(a) Does the state have mental health "parity" legislation?[108] Although federal legislation passed in 1996 offers some enhanced coverage, it does not require private insurers to provide full parity for mental health care services.[109] Some states have passed comprehensive laws requiring parity for all mental health problems and substance abuse. Some states have placed limits on the policy, and some states have weak policies because they have required parity for only a limited set of mental health problems (e.g., severe mental illness), for a limited population (e.g., state and local employees), or only for specific types of coverage (e.g., spending limits, out-of-pocket expenses) and some states have no mental health parity requirements at all.[110] Four states have the comprehensive policy: of these, all four (CT, MD, MN, VT) had this policy in last year's *Report Card*. There are four states that have a limited policy: of these, one (IN) also had a limited policy last year; one (RI) improved from a weak policy; and two (NM, KY) improved from no policy. There are 23 states that have a weak policy: of these, 20 (AZ, AR, CA, CO, DE, HI, LA, ME, MO, MT, NE, NH, NJ, NC, OK, SC, SD, TN, TX, VA) also had a weak policy last year; and three (MA, NV, UT) improved from no policy. Nineteen states and the District of Columbia do not have the policy: of these, all 19 (AL, AK, FL, GA, ID, IL, IA, KS, MI, MS, NY, ND, OH, OR, PA, WA, WV, WI, WY) and the District of Columbia also did not have the policy last year.[111]

(b) Does the state require private insurers to cover treatment for eating disorders on the same basis as other health conditions?[112] Eating disorders predominantly affect women (90 percent of cases involve adolescent or young adult women), and have one of the highest death rates of any mental disorder.[113] It is therefore important that states require private insurers to cover treatment for anorexia and bulimia on the same basis as other health problems. Some states require insurers to cover anorexia and bulimia on the same basis as other health conditions, but only in a limited way (i.e., they only require parity in spending limits or only for certain populations such as state employees); others do not have any laws requiring insurers to cover anorexia and bulimia on par with other health conditions. Eleven states have the comprehensive policy: of these, nine (AR, CA, CT, DE, IN, LA, MD, MN, VT) also had the policy in last year's *Report Card*; two (KY, NM) improved from no policy. There are six states that have a limited policy: of these, five (AZ, MO, NC, SC, TN) also had a limited policy last year; and one (UT) improved from no policy. There are 33 states and the District of Columbia that do not have a policy: of these, all 33 (AL, AK, CO, FL, GA, HI, ID, IL, IA, KS, ME, MA, MI, MS, MT, NE, NV, NH, NJ, NY, ND, OH, OK, OR, PA, RI, SD, TX, VA, WA, WV, WI, WY) and the District of Columbia also did not have the policy last year.[114]

(c) Does the state require private insurers to cover treatment for depression on the same basis as other health conditions? [115] Major depression affects twice as many women as men.[116] The *Report Card* considers states that require insurers to cover depression on the same basis as other health problems to have a comprehensive policy. Some states have a limited policy because they require insurers to cover depression on the same basis as other health conditions, but only in a limited way (i.e., they only require parity in spending limits or only for certain populations like state employees) while other states do not have any laws requiring insurers to cover depression on par with other health conditions. Twenty-two states have the comprehensive policy: of these, 20 (AR, CA, CO, CT, DE, IN, KY, LA, ME, MD, MN, MT, NE, NH, NJ, OK, RI, SD, TX, VT) also had the policy in last year's *Report Card*; two (MA, NM) improved from no policy. There are six states that have a limited policy: of these, five (AZ, MO, NC, SC, TN) also had a limited policy last year; one (UT) improved from no policy. Twenty-two states and the District of Columbia do not have the policy: of these, all 22 (AL, AK, FL, GA, HI, ID, IL, IA, KS, MI, MS, NV, NY, ND, OH, OR, PA, VA, WA, WV, WI, WY) and the District of Columbia also did not have a policy last year.[117]

Policy Indicator: Does the state require private insurance plans to cover diabetes supplies and education?[118]
Approximately six percent of women in the United States suffer from diabetes, a condition requiring self-managed treatment. Patients need access to medical supplies (including test strips, insulin and meters) and training to use these supplies and to manage their condition. It is important that states require private insurance plans to include diabetes supplies and education as part of general coverage. Some states have a limited policy because they provide coverage only for diabetes supplies or for education, but not for both. Other states have required insurers to offer to sell diabetes supplies and education coverage to customers, but have not required that it actually be included in insurance plans and therefore have a weak policy. Still other states do not require coverage at all. Currently, 40 states and the District of Columbia have the policy requiring diabetes supply and education coverage: of these, 33 (AR, CA, CO, CT, FL, IL, IN, IA, KS, KY, LA, ME, MD, MN, MT, NE, NV, NJ, NM, NY, NC, OK, PA, RI, SC, SD, TN, TX, VT, VA, WA, WV, WI) also had the policy in last year's *Report Card*; and seven (AK, HI, MA, UT, MI, OR, WY) and the District of Columbia improved from no policy.[119] There are three states that have a limited policy: of these, one (DE) also had a limited policy last year; and two (AZ, NH) dropped from having a policy. There are three states that have a weak policy: of these, all three (GA, MS, MO) also had a weak policy last year. There are four states that do not have the policy: of these, all four (AL, ID, ND, OH) also did not have the policy last year.

POLICY INDICATOR: Does the state provide comprehensive breast and cervical cancer treatment?

Thousands of women each year are diagnosed with having breast or cervical cancer. It is estimated that in 2001, 12,900 women will be diagnosed with cervical cancer and 233,000 women will be diagnosed with breast cancer nationally.[120] Furthermore, in the United States, over 44,000 women die each year from breast and cervical cancer combined.[121] Access to treatment for these cancers is crucial in saving countless women's lives. The components of this indicator reflect state efforts to provide better treatment services for women with breast and cervical cancer: (a) Medicaid coverage of breast and cervical cancer treatment; (b) private insurance coverage for reconstructive surgery after mastectomy; and (c) private insurance coverage for post-mastectomy hospital stays. Only seven states (CA, FL, IL, ME, MT, NC, PA) have the composite policy because they have all three of the policies. Twenty-three states (AK, AZ, CT, GA, IN, KS, MD, MN, MO, NE, NH, NJ, NM, NY, OK, RI, SC, TX, UT, VA, WA, WV, WI) have a limited composite policy because they have comprehensive but not complete aspects of these policies. Seventeen states (AL, AR, HI, ID, IA, KY, LA, MI, MS, NV, ND, OH, OR, SD, TN, VT, WY) and the District of Columbia have only one of the policies and therefore are considered to have a weak composite policy. Three states (CO, DE, MA) do not have any of these policies.

(a) Has the state exercised the basic option to provide Medicaid coverage for breast and cervical cancer treatment?[122] The Breast and Cervical Cancer Prevention and Treatment Act of 2000[123] went into effect October 1, 2000. This federal law fills a gap that was left by the National Breast and Cervical Cancer Early Detection Program,[124] which provides free breast and cervical cancer screening and follow-up diagnostic services to uninsured or low-income women, but does not provide treatment to those found to have breast or cervical cancer. Under the new law, however, states have the option to provide medical assistance through full Medicaid benefits to uninsured women under age 65 who were screened through the CDC's Early Detection Program and are in need of treatment ("the basic option"). A state that exercises this option receives enhanced matching funds from the federal government.[125] States can also choose to cover women screened by other providers, provide presumptive eligibility to women, or even cover others not specifically covered by the law.[126] States that have enacted legislation, approved funding for the policy, or had a plan federally approved have the policy. Those that have not completed any of those three steps do not have the policy. This component is a new addition to this composite in the 2001 *Report Card*. Forty states (AL, AK, AZ, CA, CT, FL, GA, HI, ID, IL, IN, IA, KS, ME, MD, MI, MN, MS, MO, MT, NE, NH, NJ, NC, ND, OH, OK, OR, PA, RI, SC, SD, TX, UT, VT, VA, WA, WV, WI, WY) have the policy.[127] Ten states (AR, CO, DE, KY, LA, MA, NV, NM, NY, TN) and the District of Columbia do not have the policy.

(b) Does the state require private insurers to cover reconstructive breast surgery? [128] Some insurance plans exclude coverage of breast reconstruction after a mastectomy, deeming it "cosmetic" surgery that is not medically necessary.[129] Although a federal law was passed in 1998 to combat this practice, state laws add the strength of state enforcement mechanisms.[130] States that have the policy allow coverage of reconstructive surgery with no restrictions. One state has a limited policy because it only covers reconstructive surgery when medically necessary and one state has a weak policy because it only requires insurers to offer to sell coverage. Some states do not have a policy regarding coverage of reconstructive breast surgery. Thirty-two states and the District of Columbia have the policy: of these, 28 (AZ, AR, CA, CT, FL, IL, IN, KS, LA, ME, MD, MN, MO, MT, NV, NH, NJ, NY, NC, OK, PA, RI, TN, TX, VA, WA, WV, WI) also had the policy in last year's *Report Card*; one (SC) improved from a limited policy; and three (AK, NE, UT) and the District of Columbia improved from no policy. One state (MI) still has a limited policy and one state (KY) still has a weak policy. There are 16 states that do not have a policy: of these, all 16 (AL, CO, DE, GA, HI, ID, IA, MA, MS, NM, ND, OH, OR, SD, VT, WY) also did not have a policy in last year's *Report Card*.

(c) Does the state require private insurers to cover hospital stays following a mastectomy?[131] Federal law requires that insurance companies allow physicians, in consultation with their patients, to determine how long a woman stays in the hospital following a mastectomy, based on the patient's individual needs and circumstances.[132] The law was enacted because, to the detriment of patients' health, insurance companies have denied coverage beyond a pre-determined length of stay. States that mandate coverage of physician-determined length of stay post mastectomy have the policy. Some states have a limited policy because they require private insurers to cover only a minimum length (usually 48 hours) hospital stay following a mastectomy, while other states do not have any protections for patients who have mastectomies. There has been no change among the states from the 2000 *Report Card*. Nine states (CA, FL, GA, IL, ME, MT, NY, NC, PA) have the policy. There are ten states (AR, CT, MD, NJ, NM, OK, RI, SC, TX, VA) that have a limited policy and 31 states (AL, AK, AZ, CO, DE, HI, ID, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, NE, NV, NH, ND, OH, OR, SD, TN, UT, VT, WA, WV, WI, WY) and the District of Columbia that do not have a policy.

POLICY INDICATOR: Does the state provide for access to family planning services?

Family planning services (contraceptive drugs, devices and related services) provide numerous essential health benefits – including better spacing of pregnancies leading to healthier outcomes, and fewer unintended pregnancies, abortions and sexually transmitted diseases. In fact, reducing negative health outcomes through the consistent use of effective family planning methods is one goal of Healthy People 2010.[133] Despite the importance of family planning services for women, private health insurance does not provide adequate coverage of contraceptive drugs and related services.[134] Contraceptives can be expensive, and without insurance coverage, many women are forced to either forgo using contraceptives completely or to use less effective methods. The

two component policies included in this composite indicator are: (a) required private insurance coverage for contraceptives and (b) expanded Medicaid coverage for family planning services and supplies. Nine states (CA, DE, GA, MD, MO, NM, NC, RI, WA) have both a comprehensive contraceptive coverage law and have applied for or received a Medicaid waiver to expand family planning coverage and therefore have the composite policy. Three states (CO, KY, VA) have limited or weak contraceptive coverage laws and have applied for a Medicaid waiver to expand family planning coverage, and therefore have a limited family planning composite policy. Twenty states (AL, AZ, AR, CT, FL, HI, ID, IA, ME, MN, MS, NV, NH, NJ, NY, OK, OR, TX, VT, WI) have only one of these policies and therefore have weak family planning policies. Eighteen states (AK, IL, IN, KS, LA, MA, MI, MT, NE, ND, OH, PA, SC, SD, TN, UT, WV, WY) and the District of Columbia do not have either policy.

(a) Does the state require private insurers that cover prescription drugs to cover all forms of Food and Drug Administration (FDA)-approved prescription contraceptive drugs and devices?[135] Seventeen states have the policy of requiring that private insurance companies that cover prescription drugs also cover all five FDA-approved forms of contraception: of these, 11 (CA, CT, GA, HI, IA, ME, MD, NV, NH, NC, VT) had the policy in last year's *Report Card*; one (TX) improved from a limited policy; and five (DE, NM, MO, RI, WA) improved from no policy.[136] There are six states that have a limited policy requiring that private insurance companies that cover prescription drugs also provide limited coverage for prescription contraceptives. All of these (CO, ID, KY, MN, NJ, OK) had a limited policy last year.[137] One state (VA) has a weak policy that requires that insurers offer employers purchasing plans the option and also had a weak policy last year.[138] All of the 26 states (AL, AK, AZ, AR, FL, IL, IN, KS, LA, MA, MI, MS, MT, NE, NY, ND, OH, OR, PA, SC, SD, TN, UT, WV, WI, WY) and the District of Columbia that do not have the policy also did not have the policy in last year's *Report Card*.

(b) Has the state applied for and/or received a Medicaid waiver to expand coverage for family planning services?[139] Medicaid – the largest public provider of family planning services for low-income women – is unavailable to more than half the low-income women who need these services.[140] States can expand the pool of low-income women eligible for Medicaid coverage of family planning services by securing a federal Medicaid waiver to broaden the state eligibility requirements.[141] These expansion efforts have dramatically increased the number of low-income women served by Medicaid family planning programs.[142] Twenty-one states have applied for or received this waiver and therefore have the policy: of these, 15 (AL, AZ, AR, CA, DE, FL, KY, MD, MO, NM, NY, OR, RI, SC, WA) had applied for or received the waiver in the 2000 *Report Card*; and six states (CO, GA, MS, NC, VA, WI) did not have the policy last year. All of the 29 states (AK, CT, HI, ID, IL, IN, IA, KS, LA, ME, MA, MI, MN, MT, NE, NV, NH, NJ, ND, OH, OK, PA, SD, TN, TX, UT, VT, WV, WY) and the District of Columbia that have not applied for a waiver also did not apply last year.[143]

Policy Indicator: Does the state provide for access to infertility services and adequate maternity hospital stays?
More than six million couples nationwide have trouble conceiving children after one year of trying.[144] Many private insurance companies do not cover the costs of infertility treatments, placing these expensive treatments out of financial reach for many families.[145] In many managed care settings, pregnant women are being denied coverage for hospital stays after childbirth longer than 24 hours.[146] Although being discharged soon after birth can be beneficial for many patients, other mothers and their infants can suffer negative health consequences from an early discharge. Medical experts agree that the determination about the length of a woman's hospital stay after childbirth – however short or long – should be made not by insurance companies, but by the health care provider[147] in consultation with the patient. This composite indicator measures policies that ensure that women get the services they need both while they are trying to get pregnant (requiring insurance companies to cover infertility services) and after they have given birth (requiring insurance companies to cover physician-determined hospital stays after childbirth). No state has both of these policies, and only nine states (AR, IL, MD, MA, MT, NJ, OH, RI, WV) have both laws but with coverage limits so they have a limited composite policy. Thirty-seven states (AL, AK, AZ, CA, CO, CT, FL, GA, HI, ID, IN, IA, KS, KY, LA, ME, MN, MS, MO, NE, NV, NH, NM, NY, NC, ND, OK, OR, PA, SC, SD, TN, TX, UT, VT, VA, WA) and the District of Columbia have either one of the policies or have both policies but with weaker coverage and therefore have a weak composite policy. Four states (DE, MI, WI, WY) do not have either of these policies.

(a) Does the state require that private insurance companies cover physician-determined maternity stays after childbirth?[148] Some states have a comprehensive maternity stay policy because they require insurance companies to pay for physician-determined length of stay after birth. Other states have a limited policy because they have laws requiring that insurance companies cover at least a minimum length of stay at the hospital following childbirth (usually 48 hours for vaginal delivery and 96 hours for cesareans); and others do not have a length of stay policy. Six states have the comprehensive policy: of these, all six (FL, IN, ME, VT, VA, WA) also had the policy in last year's *Report Card*.[149] Forty states and the District of Columbia have a limited policy: of these, 36 (AL, AK, AZ, AR, CA, CO, CT, GA, ID, IL, IA, KS, KY, LA, MD, MA, MN, MO, MT, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, WV) and the District of Columbia also had a limited policy last year; and three (MS, NE, UT) improved from no policy. There are five states that do not have the policy: of these, all five (DE, HI, MI, WI, WY) did not have the policy last year.

(b) Does the state require private insurance companies to provide coverage for the diagnosis and treatment of infertility?[150] Only a few states mandate insurance companies to cover infertility diagnosis and treatment.[151] Some states require limited coverage of infertility

treatment. A few states only require insurers to offer to sell coverage or refuse to cover fertility treatments for the intended purpose of producing pregnancy and therefore have a weak policy. Unfortunately, many states do not have any policy regarding infertility treatment. Five states have the policy: of these, five (HI, IL, MA, RI) also had the policy in last year's *Report Card*; and one (NJ) improved from no policy. Five states have a limited policy: of these, all five (AR, MD, MT, OH, WV) also had a limited policy last year. Five states have a weak policy: of these, four (CA, CT, NY, TX) also had a weak policy in last year's *Report Card*; and one (LA) improved from no policy. Three states have a weak policy: of these, all three (CA, CT, TX) also had a weak policy last year. Thirty-five states and the District of Columbia do not have a policy: of these, all 35 (AL, AK, AZ, CO, DE, FL, GA, ID, IN, IA, KS, KY, ME, MI, MN, MS, MO, NE, NV, NH, NM, NC, ND, OK, OR, PA, SC, SD, TN, UT, VT, VA, WA, WI, WY) and the District of Columbia also did not have a policy in last year's *Report Card*.

Policy Indicator: Does the state provide for access to abortion services?

Reproductive health care, including abortion, is a basic component of women's health care. While women in the United States have had a constitutionally protected right to abortion since the 1973 *Roe v. Wade* decision,[152] actual access to abortion services is diminishing.[153] The following components of the policy indicator reflect key policies adopted by states that protect women's access: (a) enacting clinic access laws; (b) allowing all medically accepted abortion procedures; (c) allowing minors to obtain abortions without parental consent and notification requirements; (d) allowing abortions without waiting periods; and (e) providing state funding for abortions for low-income women. Only one state (WA) has the composite policy because it has all five policies. Eleven states (CA, CO, CT, HI, MD, MA, MN, NV, NY, OR, VT) and the District of Columbia have a limited composite policy because they have adopted substantial, but not complete, aspects of these policies. Twenty-nine states (AL, AK, AZ, AR, DE, FL, GA, ID, IL, IN, IA, KS, ME, MI, MO, MT, NH, NJ, NM, NC, OK, PA, RI, TN, TX, VA, WV, WI, WY) have minimal protections and therefore have a weak composite policy. Nine states (KY, LA, MS, NE, ND, OH, SC, SD, UT) have none of these protections.

(a) Has the state passed "clinic access" legislation to protect women and providers from violence and harassment at reproductive health centers?[154] Threats and violent attacks on reproductive health centers, including murders of health care providers, have had an extremely negative impact on women's ability to obtain reproductive health services. These attacks have frightened patients away from clinics, disrupted the functioning of the clinics, and discouraged physicians and other health care professionals from providing reproductive health services.[155] In 1994, Congress passed the Freedom of Access to Clinic Entrances Act (FACE),[156] and a decline in such incidents followed immediately.[157] Several states have also passed laws to ban clinic violence, providing state police and prosecutorial authority in addition to that provided by federal authorities. Only one state (WA) has comprehensive provisions similar to FACE to protect clinic access, which it also had in the 2000 *Report Card*. Fourteen other states (CA, CO, CT, KS, ME, MD, MA, MI, MN, NV, NY, NC, OR, WI) and the District of Columbia have laws that contain less comprehensive protections, and also had these limited policies last year. Thirty-five states (AL, AK, AZ, AR, DE, FL, GA, HI, ID, IL, IN, IA, KY, LA, MS, MO, MT, NE, NH, NJ, NM, ND, OH, OK, PA, RI, SC, SD, TN, TX, UT, VT, VA, WV, WY) have no laws addressing clinic access, and did not have such laws in the last *Report Card*. Since the 2000 *Report Card*, no state has enacted a new clinic access law.

(b) Has the state allowed the availability of all medically accepted abortion procedures?[158] Over the past five years, 31 states have enacted bans on medically accepted abortion procedures, often referred to as bans on "partial birth" abortion procedures.[159] On June 28, 2000, the U.S. Supreme Court struck down the Nebraska ban as unconstitutional, because it could ban the most common abortion procedure used in the second trimester, and because, even had only one procedure been banned, there was no safeguard to allow the procedure when needed to protect a woman's health.[160] States' enactment of these bans reflects their willingness to erect barriers to women's access to medically necessary abortion services. Nineteen states (CA, CO, CT, DE, HI, ME, MD, MA, MN, NV, NH, NY, NC, OR, PA, TX, VT, WA, WY) and the District of Columbia do not have an abortion procedure ban and did not have one in last year's *Report Card* and therefore meet the policy identified in the *Report Card*. Thirty-one states have this harmful policy. Of these, 30 (AL, AK, AZ, AR, FL, GA, ID, IL, IN, IA, KS, KY, LA, MI, MS, MO, MT, NE, NJ, ND, OH, OK, RI, SC, SD, TN, UT, VA, WV, WI) had this policy last year; and one (NM) enacted this harmful policy since the 2000 *Report Card*.

(c) Does the state allow minors to obtain abortions without requiring parental consent or notification?[161] Parental consent and notification laws require that minors, usually those under age 18, involve one or both parents in their decision to terminate a pregnancy.[162] These requirements can endanger the health of young women – some young women may delay the procedure, and others may travel alone to another state to secure the abortion.[163] Eighteen states (AK, AZ, CA, CO, CT, FL, HI, IL, MT, NV, NH, NJ, NM, NY, OK, OR, VT, WA) and the District of Columbia do not have these harmful laws forcing parental involvement in a minor's decision. Two states (ME, MD) have parental involvement laws, but allow health care providers (and in Maine other counselors) to waive the requirement where appropriate, and therefore have weak policies. The remaining 30 states (AL, AR, DE, GA, ID, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, NE, NC, ND, OH, PA, RI, SC, SD, TN, TX, UT, VA, WV, WI, WY) have harmful parental consent/notification laws. There have been no additional parental involvement laws enacted since the 2000 *Report Card*.

(d) Does the state allow women to receive abortions without a mandatory waiting period?[164] Some states require a waiting period, typically 24 hours, between the time a woman receives state-mandated "counseling" and the abortion. These waiting periods are a serious barrier to women seeking abortions, making it difficult to schedule appointments, and causing delays (thereby enhancing the risk of complications).[165] They also force many women to incur greater financial costs, or to face additional harassment at clinics and from abusive partners and spouses.[166] These problems are exacerbated for the almost one-third of all women who live in counties with no abortion providers.[167] Thirty-four states (AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, HI, IL, IA, ME, MD, MA, MN, MO, MT, NV, NH, NJ, NM, NY, NC, OK, OR, RI, TN, TX, VT, WA, WV, WY) and the District of Columbia do not have these harmful laws, and none had such laws in the last *Report Card*. Sixteen states have such laws: of these, 14 (ID, IN, KS, LA, MI, MS, NE, ND, OH, PA, SC, SD, UT, WI) had such harmful laws in last year's *Report Card*. Two states (KY, VA)[168] added a waiting period since the last *Report Card*.

(e) Does the state provide funding for abortion as it does for other medically necessary procedures?[169] Women who cannot afford to pay for abortions are often unable to obtain them. Federal law prohibits the use of federal Medicaid funds to cover abortion except in cases where the pregnancy is the result of rape or incest, or the life of the woman is endangered (this law is commonly known as the "Hyde Amendment").[170] States can, however, pay for abortion services with their own funds. Seventeen states have provided funding for abortions as they do other medically necessary procedures and therefore meet policy: of these, 15 (AK, CA, CT, HI, MD, MA, MN, MT, NJ, NM, NY, OR, VT, WA, WV) had the policy in last year's *Report Card*; and two (IN, TX)[171] improved from no policy. Five states (ID, IL, IA, VA, WI) have a limited policy and provide funding in certain health circumstances for abortions beyond the federal requirement, all of which had the same policy last year. Twenty-eight states (AL, AZ, AR, CO, DE, FL, GA, KS, KY, LA, ME, MI, MS, MO, NE, NV, NH, NC, ND, OH, OK, PA, RI, SC, SD, TN, UT, WY) and the District of Columbia (pursuant to Congressional mandate) have not covered the cost of abortions for low-income women beyond those allowed under federal law, and had the same restriction last year.[172]

Policy Indicator: Does the state have laws to address the health needs of women subjected to violence?

Violence against women presents a serious health problem in need of major attention. States have attempted to reduce the impact of domestic violence and sexual assault by increasing victims' access to health care through: (a) requiring health care protocols, training and screening for domestic violence; (b) prohibiting insurance discrimination against domestic violence victims; and (c) requiring protocols for health care providers and law enforcement officials concerning sexual assault victims. Only two states (CA, NY) have the composite policy because they have all three policies. Only two states (AK, PA) have both domestic violence policies and a weaker version of the sexual assault policy and therefore have a limited composite policy. Thirty-seven states (AL, AZ, CO, CT, DE, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NE, NV, NH, NJ, NM, ND, OH, OK, OR, RI, TN, TX, UT, WA, WV, WI) have only one of these policies, or have policies that provide the most minimal protections and therefore have a weak composite policy. Nine states (AR, ID, MS, NC, SC, SD, VT, VA, WY) and the District of Columbia do not have any of these policies.

(a) Does the state require domestic violence protocols for, training for and screening by health care providers?[173] Early detection and intervention by health care providers can help domestic violence victims escape abusive relationships. Health care providers need training not only to treat appropriately women who exhibit signs of domestic violence injuries, but also to screen for and recognize abuse in a patient who does not exhibit recent injuries.[174] There are national efforts to promote protocols to help practitioners identify victims of domestic violence and perform interventions, but there is evidence that the protocols are not being routinely followed.[175] Three states have laws that help domestic violence victims get treatment by requiring: written protocols describing how health care providers should identify and treat domestic violence victims; routine screening for domestic abuse; and training to help health care providers assist domestic violence victims. All three states (CA, NY, PA) had these policies in last year's *Report Card*. There are four states (AK, MD, OH, WV) that have a limited policy because they have two out of three of these requirements; all four had the same policies in last year's *Report Card*.[176] There are six states (FL, IA, KY, OK, TX, WA) that have a weak policy because they have only one component, as they did in last year's *Report Card*. Thirty-seven states (AL, AZ, AR, CO, CT, DE, GA, HI, ID, IL, IN, KS, LA, ME, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NC, ND, OR, RI, SC, SD, TN, UT, VT, VA, WI, WY) and the District of Columbia do not have these protections for victims of domestic violence, and also did not have the policies in the 2000 *Report Card*.

(b) Does the state have a statute prohibiting discrimination against domestic violence victims in all types of private insurance?[177] Victims of domestic violence experience discrimination in all "lines" of insurance: health, life, disability and property/casualty.[178] Insurance companies have used a history of abuse to deny coverage or to increase premiums, and have refused to cover abuse-related medical conditions and claims.[179] These practices can discourage victims from seeking help for fear of losing their insurance coverage if the abuse is discovered. Although federal law offers some protection against these practices,[180] several states offer more comprehensive protection by enacting laws that prohibit discrimination against domestic violence victims. Twenty states prohibit discrimination in all four lines of insurance: of these, 15 states (AK, CA, CO, DE, HI, IA, MA, MO, MT, NE, NM, NY, OR, PA, WA) had the policy in last year's *Report Card*; one (AZ) improved from a limited policy; and four of these improved from no policy (AL, GA, NH, WI). There are six states (IL, IN, KS, ME, UT, WV) that bar discrimination in three lines of insurance

and therefore have a limited policy; they have not changed since the 2000 *Report Card*. There are 14 states that bar discrimination in one or two lines of insurance: of these, 13 (CT, FL, LA, MD, MI, MN, NV, NJ, ND, OH, RI, TN, TX) had the policy in last year's *Report Card*; and one state (KY) has added minimal protection since the 2000 *Report Card*. Ten states (AR, ID, MS, NC, OK, SC, SD, VT, VA, WY) and the District of Columbia do not have laws protecting domestic violence victims from insurance discrimination and have not changed since the 2000 *Report Card*.

(c) Does the state have laws that require training for health care providers, police and prosecutors in handling sexual assault cases? [181]
Victims of sexual assault are often subject to inadequate or inappropriate responses from health care providers, police and prosecutors. For example, health care providers may not be adequately trained in how to care for victims during evidence collection (or even how to perform the collection), and police and prosecutors may not be sufficiently sensitive to the special traumas sexual assault victims face. Six states have laws requiring both that health care providers be trained in sexual assault evidence collection, and that police and prosecutors be trained in dealing with sexual assault victims: of these, four (AK, CA, CT, IL) had the policy in last year's *Report Card*; and two (KY, NY) improved from a limited policy. There are ten states that require one of the two training programs: of these, nine (LA, MD, MA, NJ, NM, OH, PA, TX, WA) had a limited policy in last year's *Report Card*; and one (FL) added a police and prosecutor training requirement since last year. The remaining 34 states (AL, AZ, AR, CO, DE, GA, HI, ID, IN, IA, KS, ME, MI, MN, MS, MO, MT, NE, NV, NH, NC, ND, OK, OR, RI, SC, SD, TN, UT, VT, VA, WV, WI, WY) and the District of Columbia do not have either training requirement and have not added either of them since the 2000 *Report Card*.

Addressing Wellness and Prevention

In recognition of the growing consensus about the importance of promoting wellness and preventing illness, the *Report Card* includes indicators on screening tests, personal behaviors that can influence health, and ways in which women and health care providers can prevent and manage illness and maintain or improve health.

Screening

The *Report Card* examines screening for cervical cancer, chlamydia, breast cancer, colorectal cancer and osteoporosis. These tests (intended to be given even when women do not have symptoms) were selected because the diseases for which they screen can effectively be treated with early interventions. Furthermore, these screening tests are often the first step for women gaining access to general health care services. Both Medicaid and Medicare provide certain preventive screenings (for example, states are required to cover Pap smears and mammograms under Medicaid, and Medicare covers both of those screenings as well).[182] However, states can supplement what is provided under publicly funded health insurance programs by requiring private insurers to cover important screenings for women. The policy indicators below focus on these private insurance requirements regarding Pap smears, chlamydia screening, mammograms, bone density screening and colorectal cancer screening.

Status Indicator: What percentage of women age 18 and over have had a Pap test within the past three years?[183]
Papanicolaou (Pap) smears remain the primary screening test to help prevent cervical cancer. Nevertheless, many women have not received a Pap smear in the past three years. This is especially true for older women, uninsured women and women in some minority groups.[184] The *Report Card's* benchmark is the Healthy People 2000 goal that at least 85 percent of women age 18 and over have received a Pap smear in the past three years.[185] Thirty-six states and the District of Columbia meet the benchmark and receive an "S": of these, 18 states (MT, NE, NH, NM, NY, NC, OH, OK, OR, PA, RI, SC, SD, TN, VT, VA WA, WI) also met the benchmark in last year's *Report Card*; and 18 states (AL, AK, AZ, CO, CT, DE, GA, HI, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS) and the District of Columbia improved from a "U". There are 14 states that are within ten percent of the benchmark and receive a "U": of these, seven states (AR, CA, FL, ID, IL, IN, MO) also received a "U" last year; and seven states (NV, NJ, ND, TX, UT, WV, WY) dropped from an "S". The nation receives an "S", improving from a "U" last year.

Policy Indicator: Does the state require private insurers to cover annual Pap smears and cervical cancer screening?[186]
Although the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program covers the cost of Pap smears for certain categories of underserved women,[187] many women who need these screening tests would not receive them if states did not take additional steps to provide coverage. Some states provide adequate screening for cervical cancer by requiring private insurers to cover annual Pap smears, one state requires insurers to offer to sell coverage and therefore has a limited policy, and other states do not require insurers to cover annual Pap smears. Twenty-three states and the District of Columbia have the policy: of these, 22 (AK, CA, DE, GA, IL, KS, LA, ME, MA, MN, MO, NV, NJ, NM, NY, NC, OR, PA, RI, SC, VA, WV) and the District of Columbia also had the policy in last year's *Report Card*; and one (WY) improved from no policy. One state (OH) continues to have a limited policy. There are 26 states that do not have the policy: of these, all 26 (AL, AZ,

AR, CO, CT, FL, HI, ID, IN, IA, KY, MD, MI, MS, MT, NE, NH, ND, OK, SD, TN, TX, UT, VT, WA, WI) did not have the policy in the 2000 *Report Card*.[188]

Policy Indicator: Does the state require private insurers to cover screening tests for chlamydia?[189]

Chlamydia is the most common bacterial sexually transmitted disease and is most prevalent among young women age 15 to 25.[190] The Centers for Disease Control and Prevention recently recommended that sexually active women under the age of 25 be screened for chlamydia every six months, noting that in one study, almost one in three such women tested positive.[191] Screening for chlamydia is also recommended for all women in high-risk categories, including those who have had a sexually transmitted disease, have a new partner or multiple partners, or inconsistently use barrier contraceptives.[192] Only two states require insurers to cover the recommended screening for chlamydia: of these, both (GA, MD) had the policy in last year's *Report Card*. There is one state (TN) that requires insurers to offer coverage for screenings, but does not actually require that it be included in insurance plans, and therefore has a weak policy, as it did last year.[193] The remaining 47 states (AL, AK, AZ, AR, CA, CO, CT, DE, FL, HI, ID, IL, IN, IA, KS, KY, LA, ME, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TX, UT, VT, VA, WA, WV, WI, WY) and the District of Columbia do not require chlamydia screening coverage and did not have the policy in the 2000 *Report Card*.

Status Indicator: What percentage of women age 50 and over have had a mammogram within the past two years?[194]

Mammograms help detect breast cancer in its early stages; it is critical that women have access to them. Although the overall number of women who get mammograms is increasing, a number of women – particularly those who are uninsured, older and members of certain racial and ethnic minority groups – do not get mammograms at the same rate.[195] In all 50 states and the District of Columbia, at least 60 percent of women age 50 and over received a mammogram within the past one to two years, thereby meeting the Healthy People 2000 goal.[196] Therefore, the 50 states, the District of Columbia and the nation as a whole receive an "S", as they did in last year's *Report Card*. However, Healthy People 2010 has set the new goal of mammograms every two years for women 40 and over.[197] Future analyses will determine whether states meet this new benchmark, and whether there is improvement among groups of women who currently tend not to get mammograms.

Policy Indicator: Does the state require private insurers to cover annual mammograms and breast cancer screening?[198]

Although the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program covers mammograms for certain categories of underserved women, many women who need these screenings still would not receive them if states failed to take additional steps to provide coverage.[199] States that require private insurers to cover annual mammograms for women age 40 and over are considered to have comprehensive breast cancer screenings.[200] Some states have a limited policy that requires private insurers to cover annual mammograms for a narrower category of women (the majority of these states cover annual mammograms for women age 50 and over). Others have a weak policy because they only require that insurance companies offer to sell coverage of mammograms to customers, but have not actually required that it be included in insurance plans. There are a few states that do not have any requirements regarding insurance coverage for mammograms. Sixteen states and the District of Columbia have the policy: of these, 14 (HI, IL, IN, ME, MA, NV, NJ, ND, OK, OR, PA, RI, SC, TX) and the District of Columbia also had the policy in last year's *Report Card*; one (CT) improved from a limited policy; and one (WY) improved from no policy. There are 27 states that have a limited policy: of these, all 27 (AL, AK, AZ, CA, CO, DE, FL, GA, ID, IA, KS, KY, LA, MD, MO, MT, NE, NH, NM, NY, NC, SD, TN, VT, VA, WV, WI) also had a limited policy in last year's *Report Card*. There are four states that have a weak policy: of these, all four (AR, MI, MS, OH) also had a weak policy last year. There are three states that do not have the policy: of these, all three (MN, UT, WA) also did not have the policy last year.

Policy Indicator: Does the state require private insurers to cover bone density screening for certain high-risk groups? [201]

Bone density testing (also known as bone mass measurement) can predict a woman's risk for bone fractures (one of the most common and debilitating consequences of osteoporosis).[202] Although Medicare covers bone density testing for five high-risk groups, states can help cover more women who need the test by requiring private insurers to cover high-risk people not covered by Medicare.[203] States that have the policy require private insurers to cover bone density screening for people not otherwise eligible for Medicare in all five high-risk categories. One state requires private insurers to cover bone density screening for three of the five categories. Some states have a limited policy that only require insurers to offer to sell coverage, while others do not have a policy at all. Seven states have the policy: of these, five (FL, MD, NC, OK, TX) also had the policy in last year's *Report Card*; and two (KS, MO) improved from no policy.[204] One state (LA) still has a limited policy. There are two states (GA, KY) that have a weak policy, as they did in last year's *Report Card*. Forty states and the District of Columbia do not have the policy: of these, all 40 (AL, AK, AZ, AR, CA, CO, CT, DE, HI, ID, IL, IN, IA, ME, MA, MI, MN, MS, MT, NE, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, SC, SD, TN, UT, VT, VA, WA, WV, WI, WY) and the District of Columbia did not have a policy last year.

Status Indicator: What percentage of women age 50 and over have ever had a sigmoidoscopy? [205]

Colorectal cancer is the third leading cause of cancer-related deaths among women after lung and breast cancer.[206] Colorectal cancer is most common in people age 50 and over and the risk increases with age.[207] Regular screening examinations can reduce a person's risk of developing colorectal cancer and are recommended for people age 50 and over.[208] One commonly recommended screening procedure is a sigmoidoscopy.[209] The *Report Card's*

benchmark is the Healthy People 2000 goal that at least 40 percent of people age 50 and over have had a sigmoidoscopy at some point in their lives (when applied to women).[210] Thirty-four states and the District of Columbia meet the benchmark and receive an "S": of these, 17 states (AL, CA, CT, DE, FL, GA, HI, ME, MI, MN, MT, OR, UT, VA, WA, WI, WY) and the District of Columbia also met the benchmark in last year's *Report Card*; nine (AK, CO, ID, IL, IA, NH, RI, TX, VT) improved from a "U"; and eight states (AR, IN, MD, MA, NV, NM, SC, SD) improved from an "F". There are 11 states that are within ten percent of the benchmark and receive a "U": of these, four states (AZ, MS, NY, NC) also received a "U" last year; five (KS, NJ, OH, PA, TN) improved from an "F"; and two (MO, ND) dropped from an "S". There are five states that miss the benchmark by more than ten percent and receive an "F": these five (KY, LA, NE, OK, WV) also received an "F" last year. The nation receives an "S", and improved from a "U" last year.

POLICY INDICATOR: Does the state require private insurers to cover colorectal cancer screening? [211]

Early detection and treatment can greatly reduce the risks associated with colorectal cancer.[212] Several states require private insurers to cover colorectal cancer screening. Fourteen states have the policy: of these, two (IL, MO) also had the policy in last year's *Report Card*; and 12 (CT, DE, IN, MD, NJ, NC, OK, RI, TX, VA, WV, WY) improved from no policy. Thirty-six states and the District of Columbia do not have a policy: of these, all 36 (AL, AK, AZ, AR, CA, CO, FL, GA, HI, ID, IA, KS, KY, LA, ME, MA, MI, MN, MS, MT, NE, NV, NH, NM, NY, ND, OH, OR, PA, SC, SD, TN, UT, VT, WA, WI) and the District of Columbia also did not have the policy in last year's *Report Card*.[213]

Prevention

Exercising, eating right, maintaining a healthy weight, not smoking, drinking alcohol only in moderation and having an annual dental visit can improve or maintain a woman's general health and well-being, and can reduce both the risks of getting certain diseases and the consequences of these diseases. The *Report Card* includes indicators that reflect state efforts to encourage these positive health behaviors.

STATUS INDICATOR: What percentage of women have not engaged in any leisure-time physical activity in the past month? [214]

Regular exercise is critical to maintaining good health and preventing severe illness, yet almost one-third of women report no leisure time physical activity. All 50 states and the District of Columbia miss by more than ten percent the Healthy People 2000 goal of reducing to no more than 15 percent the proportion of people who engage in no leisure time physical activity (when applied to women).[215] They therefore receive an "F" as they did in last year's *Report Card*. The nation also receives an "F", as it did last year.

POLICY INDICATOR: Does the state require students in grades nine through 12 to take four years of physical education in order to graduate? [216]

Currently, half of teenagers nationwide report that they do not engage in regular vigorous physical activity, and girls are far more likely than boys to report being inactive.[217] Promoting physical activity in school is crucial to encouraging girls to reap the health benefits of regular exercise and to develop lifelong good exercise habits.[218] The percentage of young people who are overweight has doubled since 1980, while the percentage of high school students enrolled in daily physical education classes has declined by 30 percent between 1991 and 1999.[219] The data for the 2000 *Report Card* have not been updated. Only one state requires students in grades nine through 12 to take four years of Physical Education (P.E.) to graduate.[220] Some states have a limited policy because they require students to take less than four years of P.E. to graduate, and other states either have no P.E. graduation requirement or specify that the local district should determine the requirement.[221] Only one state (NJ) has the policy. Thirty-six states (AL, AK, AR, CA, CT, DE, FL, GA, HI, ID, IA, KS, KY, LA, ME, MD, MO, MT, NE, NV, NH, NM, NY, NC, ND, OH, OR, RI, SC, TX, UT, VT, VA, WA, WV, WI) and the District of Columbia have a limited policy, and 13 states (AZ, CO, IL, IN, MA, MI, MN, MS, OK, PA, SD, TN, WY) do not have a policy.

STATUS INDICATOR: What percentage of women are overweight? [222]

As in last year's *Report Card*, no state meets the Healthy People 2000 goal of reducing the percentage of overweight persons (age 20 and over) to 20 percent or less (when applied to women).[223] This failure has serious implications for women's health, since being overweight is associated with a greater risk of diseases such as cardiovascular disease and diabetes, and of exacerbating existing conditions such as arthritis.[224] No state meets the benchmark and therefore no state receives an "S". Only one state (AZ) is within ten percent of the benchmark and receives a "U", as it did in last year's *Report Card*. The remaining 49 states and the District of Columbia and the nation as a whole miss the benchmark by more than ten percent and receive an "F", as they did last year.

STATUS INDICATOR: What percentage of women eat five or more servings of fruits and vegetables a day? [225]

One of the best ways to assess a healthy diet is to count the number of servings of fruits and vegetables an individual eats in a day.[226] Poor nutrition increases both the prevalence and the severity of many conditions (including obesity, high blood pressure, osteoporosis and arthritis) and illnesses (including cardiovascular diseases, diabetes and certain cancers).[227] The Healthy People 2000 goal is to increase to at least 50 percent the proportion of people age two and over who eat five or more servings of fruits and vegetables a day.[228] As in last year's *Report Card*, no state meets the benchmark (when the goal was applied to women) and therefore no state receives an "S". All 50 states and the District of Columbia and the nation as a whole again miss the benchmark by more than ten percent and receive an "F".

Policy Indicator: Does the state have nutrition outreach and education programs?

One of the greatest barriers to good nutrition for many low-income women is lack of information – both about the services available and about healthy eating. Two programs that states can adopt to counteract this problem are (a) outreach programs to women eligible for Food Stamps and (b) the Food Stamp Nutrition Education Program to teach safe and healthy eating. Fourteen states (AZ, CT, IN, KY, MA, MN, NH, NY, PA, SC, TN, TX, VT, WA) participate in both programs. Thirty-four states (AL, AR, CA, CO, FL, GA, HI, ID, IL, IA, KS, LA, ME, MD, MI, MS, MO, MT, NE, NV, NJ, NM, NC, ND, OH, OK, OR, RI, SD, UT, VA, WV, WI, WY) participate in one or the other and therefore have a limited composite policy. Two states (AK, DE) and the District of Columbia do not participate in either program and have no policy.[229]

(a) Is the state using federal matching funds to conduct outreach to ensure that all eligible individuals are enrolled in the Food Stamp Program?[230] The Food Stamp Program helps eligible low-income people (the majority of whom are women) buy nutritious food, and outreach efforts are critical to ensuring that these eligible people participate.[231] Since the enactment of welfare reform legislation, Food Stamp enrollment has declined, possibly because some people who were no longer eligible for some types of public assistance mistakenly believed that they also were not eligible for Food Stamps.[232] By using federal matching funds to inform people that they are still eligible for Food Stamps, states can ensure that these low-income people get enough food. Fourteen states conduct outreach with these federal funds: of these, nine states (AZ, CT, KY, MA, NH, NY, TN, VT, WA) conducted outreach last year; and five states (IN, MN, PA, SC, TX) improved from having no policy. Thirty-six states (AL, AK, AR, CA, CO, DE, FL, GA, HI, ID, IL, IA, KS, LA, ME, MD, MI, MS, MO, MT, NE, NV, NJ, NM, NC, ND, OH, OK, OR, RI, SD, UT, VA, WV, WI, WY) and the District of Columbia do not conduct federally funded outreach, and did not do so in last year's *Report Card*.

(b) Does the state have a Food Stamp Nutrition Education Program?[233] States that participate in the Food Stamp Nutrition Education Program (FSNEP) can receive federal matching funds if they demonstrate that their programs educate Food Stamp recipients about healthy eating, handling food safely, and managing a food budget. Forty-eight states have this program: of these, 47 (AL, AZ, AR, CA, CO, CT, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY) also had the policy in last year's *Report Card*; and one state (MD) has initiated a nutrition education program since the 2000 *Report Card*, improving from no policy. Two states (AK, DE) and the District of Columbia do not have a program and also did not have a program last year.[234]

Status Indicator: What percentage of women smoke? [235]

Since 1980, approximately three million women in the United States have died prematurely from smoking-related illnesses.[236] Lung cancer is the leading cause of cancer deaths among U.S. women and about 90 percent of lung cancer death among women smokers are attributable to smoking.[237] There has been a 600 percent increase in women's death rates for lung cancer since 1950.[238] Nationally, approximately one in four adult women and one in three high school senior girls smoke.[239] Although male and female smokers share increased risks for certain diseases (e.g., cancer, heart disease, and emphysema), women experience unique smoking risks relative to pregnancy, oral contraceptive use, menstrual function, and cervical cancer.[240] Although smoking prevalence has decreased from 33.9 percent in 1965, to 22 percent in 1998, most of this decrease occurred from 1974 through 1990, with little improvement being shown in the last ten years.[241] The 2001 Surgeon General's report on women and smoking highlights smoking as a critical women's health issue.[242] The *Report Card's* benchmark is the Healthy People 2000 goal of reducing the percentage of people 18 and over who smoke cigarettes to 15 percent or less (when applied to women).[243] Two states meet the benchmark and receive an "S": of these, one state (UT) also met the benchmark in last year's *Report Card*; and one state (CA) improved from an "F." One state (HI) is within ten percent of the benchmark and receives a "U", improving from an "F". Forty-seven states and the District of Columbia miss the benchmark by more than ten percent and receive an "F": of these, 46 states (AL, AK, AZ, AR, CO, CT, DE, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, VT, VA, WA, WV, WI, WY) and the District of Columbia also received an "F" last year; and one state (MN) dropped from a "U". The nation receives an "F", as it did last year.

Policy Indicator: Does the state have strong anti-smoking policies?

As noted above, the 2001 Surgeon General's report on women and smoking highlights smoking as a critical women's health issue.[244] State anti-smoking efforts are critical to ensuring both that non-smokers do not start smoking and that smokers stop. Thus, the *Report Card* examines: (a) state Medicaid smoking cessation coverage; (b) the state rate of tobacco sales to minors; (c) laws banning indoor smoking; (d) excise taxes on cigarettes; and (e) state funding levels for tobacco prevention efforts. No state has adopted strong forms of all five of these policies, and seven states (CA, FL, ME, MD, MI, NH, VT) have made substantial efforts to reduce smoking by adopting all of these policies with most of them in a moderately strong form and therefore have a limited composite policy. Forty-three states (AL, AK, AZ, AR, CO, CT, DE, GA, HI, ID, IL, IN, IA, KS, KY, LA, MA, MN, MS, MO, MT, NE, NV, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WV, WI, WY) and the District of Columbia have fewer or weaker versions of these policies and therefore have a weak composite policy. Every state has at least some policy.

(a) How comprehensive is the state's private insurance and Medicaid smoking cessation treatment coverage?[245] The numerous major health problems associated with smoking make smoking cessation efforts a critical component in improving overall health.[246] A smoker who quits before age 50 cuts in half her risk of dying in the next 15 years.[247] In both the 2000 and 2001 *Report Cards*, no state had enacted laws requiring private insurers to cover smoking cessation treatments.[248] States that have the policy have Medicaid programs that cover all three forms of smoking cessation treatment (over the counter treatments, prescription treatments, and smoking cessation counseling).[249] States in which Medicaid covers two of the three treatment categories are considered to have a limited policy. State Medicaid programs that cover only one category of treatment are considered weak, and others that do not cover any of the three categories have no policy. The data from last year's *Report Card* concerning Medicaid programs have not been updated. Only six states (CA, FL, ME, MN, NM, OR) have the policy. There are 12 states (CO, DE, LA, MD, MI, NV, NH, ND, OH, TX, VT, WI) with a limited policy. Six states (AZ, KS, MT, NJ, NC, OK) and the District of Columbia have a weak policy, and 25 states (AL, AK, AR, CT, GA, HI, ID, IL, IN, IA, KY, MA, MS, MO, NE, NY, PA, RI, SC, SD, TN, UT, WA, WV, WY) do not have a policy. Virginia did not respond to the survey from which this data are drawn.

(b) What is the state's sales rate of tobacco products to minors?[250] Women who start smoking as adolescents are more likely to be heavy adult smokers than those who start later.[251] A good way to prevent adult women from smoking is to ensure that they never start as children. Currently, more than 40 percent of high school students report using tobacco and are already on their way to assuming the health risks associated with smoking.[252] All states ban the sale of tobacco products to minors. A state's effectiveness in enforcing its ban is measured by a "tobacco sales rate" that reflects the annual percentage of merchants who break the law by selling tobacco products to minors.[253] States have the policy if they have a sales rate to minors below ten percent (the target set by health experts).[254] States have a limited policy if their sales rates are between ten and up to and including 20 percent (the target set by the federal government), and states have a weak policy if they have a sales rate over 20 percent.[255] Five states have this policy: of these, three (FL, ME, NH) also had the policy in last year's *Report Card*; and two (LA, SD) improved from a limited policy. In addition, Florida has a particularly effective anti-smoking public education campaign targeted at youth.[256] There are 19 states that have a limited policy: of these, 11 (AL, CA, HI, IL, KY, MA, NM, NY, TX, UT, WA) also had a limited policy in last year's *Report Card*; seven (AR, CO, CT, ND, OK, OR, SC) improved from a weak policy; and one (VT) dropped from having a policy. There are 26 states that have a weak policy: of these, 23 (AK, AZ, DE, ID, IN, IA, KS, MD, MI, MN, MS, MO, MT, NE, NJ, NC, OH, PA, RI, TN, WV, WI, WY) and the District of Columbia also had a weak policy in last year's *Report Card*; and three (GA, NV, VA) dropped from a limited policy. Every state has at least some policy.

(c) Does the state have laws restricting indoor smoking and how restrictive are those laws?[257] The U.S. Environmental Protection Agency (EPA) has classified environmental tobacco smoke (ETS, also called "second-hand smoke") as a Group A carcinogen.[258] Like cigarette smoking, ETS can lead to lung cancer, heart disease and many other life-threatening conditions for smokers and also for non-smokers, making it a major public health hazard.[259] States can help prevent exposure to ETS by completely prohibiting smoking in indoor sites, including government and private worksites, schools, day care centers, health care facilities and places of public access (e.g., elevators, public transit shopping centers or restaurants). Since the 2000 *Report Card*, there have been no changes in state policies for this smoking component. Only four states (CA, MD, UT, VT) have the policy. There are eight states (HI, ME, MI, MN, NH, NY, WA, WI) that have a limited policy. There are 25 states (AK, AZ, CO, CT, DE, FL, ID, IL, IA, KS, LA, MA, MO, NE, NV, NJ, ND, OH, OK, OR, RI, SC, SD, TN, VA) and the District of Columbia that have a weak policy. There are 13 states (AL, AR, GA, IN, KY, MS, MT, NM, NC, PA, TX, WV, WY) that do not have a policy.

(d) Does the state have an excise tax on cigarettes of one dollar or more per pack? [260] Increasing the excise tax on cigarettes is one of the most effective ways to reduce smoking, especially among youth. Current research shows that a ten percent increase in the price of cigarettes leads to a seven percent reduction in teenage smoking and a six percent reduction in overall smoking.[261] Moreover, when excise taxes support a comprehensive tobacco control program, decreases in consumption will continue even if tobacco prices are lowered to pre-excise tax values.[262] Some states have the policy because they have an excise tax of at least one dollar per pack (a pack is 20 cigarettes). States have a limited policy if their excise tax is between $0.50 and $0.99 per pack, and states have a weak policy when their excise tax is $0.49 and below per pack. Since the 2000 *Report Card*, there have been no changes in this smoking component. Three states (AK, HI, NY) have the policy; New York has the highest excise tax of $1.11 per pack. Fifteen states (AZ, CA, CT, IL, ME, MD, MA, MI, NH, NJ, OR, RI, UT, WA, WI) and the District of Columbia have a limited policy. There are 32 states (AL, AR, CO, DE, FL, GA, ID, IN, IA, KS, KY, LA, MN, MS, MO, MT, NE, NV, NM, NC, ND, OH, OK, PA, SC, SD, TN, TX, VT, VA, WV, WY) that have a weak policy. Every state has at least some policy.

(e) Does the state's funding for tobacco prevention meet the CDC's minimum recommended funding for that state?[263] Comprehensive tobacco control programs have been shown to be effective in preventing and reducing tobacco use.[264] The Centers for Disease Control and Prevention have studied the elements of successful state comprehensive tobacco control programs and have recommended appropriate funding levels for each state to implement such a program. Each recommendation is based on specific characteristics of the state and is in the form of a funding range, with a lower and upper estimate for the total annual cost of a comprehensive tobacco control program.[265] The November 1998 multi-state settlement of the lawsuits against tobacco companies

for $206 billion, as well as states' individual settlements with tobacco companies, have greatly increased the funds available to states for tobacco control. In addition, states have excise tax revenues and other funding streams they can use for tobacco control efforts.[266] States have the *Report Card* policy when they fund tobacco prevention annually at levels falling within the CDC's recommended range. States that have funding levels that are at or greater than 50 percent of the CDC's recommended range have a limited policy. States with funding levels less than 50 percent of the CDC's minimum recommendation have a weak policy. States that have not committed any annual funds to tobacco prevention or have not yet decided how to allocate their settlement funding are considered not to have a policy.[267] Six states (AZ, IN, ME, MA, MN, MS) have the policy. There are 11 states (AR, CA, CO, FL, HI, MD, NE, NJ, OH, VT, WI) that have a limited policy. There are 27 states (AL, AK, CT, DE, GA, ID, IL, IA, KS, KY, LA, MT, NV, NH, NM, NY, OK, OR, RI, SC, SD, TX, UT, VA, WA, WV, WY) that have a weak policy. Six states (MI, MO, NC, ND, PA, TN) and the District of Columbia do not have a policy. This indicator is new in the 2001 *Report Card*.

Status Indicator: What percentage of women have had five or more drinks on at least one occasion during the past month?[268]

Excessive alcohol use is dangerous to a woman's health. While chronic alcohol use is a known health problem, binge drinking (having five or more drinks on at least one occasion) is an especially hazardous form of alcohol abuse.[269] The *Report Card's* benchmark is the Healthy People 2010 goal of reducing the percentage of adults who engage in binge drinking to six percent or less (when applied to women).[270] Fourteen states meet the benchmark set by Healthy People 2010 when the goal was applied to women, and receive an "S": of these, 13 states (AZ, AR, GA, KS, KY, MS, NC, OH, OK, SC, TN, UT, WV) also met the benchmark in last year's *Report Card*; and one state (FL) improved from a "U". There are six states that are within ten percent of the benchmark and receive a "U": of these, one state (NM) also received a "U" last year; three states (CT, HI, LA) improved from an "F" and two states (AL, ME) dropped from an "S". Thirty states and the District of Columbia miss the benchmark by more than ten percent and receive an "F": of these, 23 states (AK, CA, CO, ID, IL, IA, MA, MI, MN, MO, MT, NE, NV, NH, ND, OR, PA, RI, SD, TX, VT, WI, WY) and the District of Columbia also received an "F" last year; three states (DE, MD, NY) dropped from an "S"; and four states (IN, NJ, VA, WA) dropped from a "U." The nation receives an "F", as it did last year.

Status Indicator: What percentage of women have had a dental visit within the past year?[271]

The 2000 Surgeon General's report *Oral Health in America* stresses that oral health is integral to general health and well-being.[272] Poor oral health and untreated oral conditions not only can result in irreversible dental decay, but also may affect women differently than they affect men and are associated with many diseases and conditions that affect women such as diabetes, heart and lung diseases, stroke, and low birth-weight, premature births.[273] There are significant disparities by race/ethnicity and socioeconomic status for oral health status and access to dental care services.[274] Routine dental visits aid in the prevention, early detection and treatment of oral diseases. The *Report Card's* benchmark is the Healthy People 2000 goal of increasing the number of people age 35 and over using the oral health care system each year to at least 70 percent (when applied to women).[275] For this new *Report Card* status indicator, 26 states (AK, CO, CT, DE, HI, IL, IA, KS, ME, MD, MA, MI, MN, NE, NH, NJ, NY, ND, PA, RI, SC, TN, UT, VT, VA, WI) and the District of Columbia meet the Healthy People 2000 goal and receive an "S". Sixteen states (AZ, CA, FL, GA, ID, IN, KY, MO, MT, NM, NC, OH, OR, SD, WA, WY) come within ten percent of the benchmark and receive a "U". Eight states (AL, AK, LA, MS, NV, OK, TX, WV) miss the benchmark by more than ten percent; they receive an "F". The nation meets this benchmark and receives an "S".

Policy Indicator: Does the state have a Comprehensive Capacity Diabetes Control Program that it supplements with state funds?[276]

The high rate of diabetes (particularly among women) has led the Centers for Disease Control and Prevention to fund State Diabetes Control Programs to: improve public understanding of diabetes; develop prevention and control strategies and opportunities; and increase access to care.[277] States that demonstrate a strong commitment to preventing and controlling diabetes not only receive the Centers for Disease Control and Prevention's highest funding level ("comprehensive" funding) that averages $800,000 per state annually, but also supplement the funding with state funds. States have a limited policy if they receive comprehensive funding but do not supplement the funding with state funds. Other states have not demonstrated a strong enough commitment to warrant receiving more than the "core" CDC funding (an average of $232,000 per state annually) and therefore do not have a policy. Six states have the policy: of these, three (IL, MN, NC) also had the policy in last year's *Report Card*; and three (MA, UT, WI) improved from a limited policy. There are ten states that have a limited policy: of these, seven (CA, MT, OH, OR, RI, WA, WV) also had a limited policy in last year's *Report Card*; and three (MI, NY, TX) dropped from having a policy. The remaining 34 states and the District of Columbia do not have a policy: of these, all 34 (AL, AK, AZ, AR, CO, CT, DE, FL, GA, HI, ID, IN, IA, KS, KY, LA, ME, MD, MS, MO, NE, NV, NH, NJ, NM, ND, OK, PA, SC, SD, TN, VT, VA, WY) and the District of Columbia also did not have a policy in last year's *Report Card*.

Policy Indicator: Does the state receive the higher level of federal funds to expand its arthritis program?[278]

A large number of women in the United States, particularly women of color, suffer from arthritis. A state's participation in the federally funded state-based arthritis program is critical to increasing awareness of arthritis as a public health problem and creating education, intervention and treatment strategies for people living with arthritis. The Centers for Disease Control and Prevention (CDC) provide two funding levels for the state-based

arthritis programs, awarding higher funding to states demonstrating a greater commitment to addressing arthritis.[279] States have the policy if they receive the higher federal funding level. States have a limited policy if they receive the lower funding level. States have weak policies if they apply for, but do not receive, any federal funding for expanding their arthritis programs. States have no policy if they do not apply for federal funds. Eight states have the policy: of these, all eight (AL, CA, FL, GA, IL, MN, MO, UT) had the policy in last year's *Report Card*.[280] There are 21 states that have limited policies: of these, 17 (AK, AZ, CT, ID, IA, KS, KY, MI, NM, NC, OH, OK, OR, RI, SC, TN, VA) had a limited policy last year; four (AR, IN, NY, WI) improved from weak policies. There are 14 states that have weak policies: of these, two (PA, TX) had weak policies last year; one (NV) improved from no policy; and 11 (CO, HI, MD, MA, MS, NE, NJ, ND, VT, WA, WY) dropped from having a limited policy. There are seven states and the District of Columbia that do not have a policy: of these, four (DE, MT, SD, WV) also had no policy last year; two (ME, NH) dropped from a limited policy; and one (LA) and the District of Columbia dropped from a weak policy.

Policy Indicator: Does the state fund an osteoporosis public education program?[281]

Osteoporosis public education programs help to prevent the disease and improve treatment outcomes by increasing public awareness and understanding of osteoporosis and by helping health care professionals learn how to prevent, diagnose and treat it.[282] The data from last year's *Report Card* have not been updated. Some states have state-funded osteoporosis public education programs (funding levels for these programs range from $2,500 to $750,000) and others do not have the policy. Twenty-six states (AL, AZ, CA, CT, DE, FL, IL, IN, MD, MA, MI, MO, NH, NJ, NM, NY, NC, OH, PA, RI, SC, TN, TX, VA, WA, WV) have the policy, and 24 (AK, AR, CO, GA, HI, ID, IA, KS, KY, LA, ME, MN, MS, MT, NE, NV, ND, OK, OR, SD, UT, VT, WI, WY) and the District of Columbia do not have a state-funded osteoporosis public education program.

Policy Indicator: Does the state require sexuality and STD/HIV education in public schools?

Healthy People 2010 seeks to increase the number of young adults receiving school-based education both on contraception and abstinence and on sexually transmitted diseases (STDs) and HIV prevention.[283] The U.S. Surgeon General issued a report in 2001 emphasizing the important role of comprehensive school-based programs in promoting responsible sexual behavior and lessening some of the serious sexually related public health problems suffered by the nation.[284] Sexuality and STD/HIV education is one of the best ways to reduce and prevent unintended pregnancy and the spread of sexually transmitted diseases, including HIV/AIDS.[285] Only six states (DE, HI, NJ, RI, VT, WV) have both policies,[286] and therefore meet policy. Only eight states (AL, CA, KY, MI, NM, OK, OR, PA) have one of the two policies, and therefore have a limited composite policy.[287] The remaining 36 states (AK, AZ, AR, CO, CT, FL, GA, ID, IL, IN, IA, KS, LA, ME, MD, MA, MN, MS, MO, MT, NE, NV, NH, NY, NC, ND, OH, SC, SD, TN, TX, UT, VA, WA, WI, WY) and the District of Columbia do not have either policy.

(a) Does the state require that sexuality education be taught and that it include information about both contraception and abstinence?[288] States can promote sexuality education by requiring school-based sexuality education and enacting content requirements for these programs that include both contraception and abstinence.[289] Six states have mandated sexuality education programs and have a content requirement that includes both contraception and abstinence. Of these, all six (DE, HI, NJ, RI, VT, WV) had the policy in last year's *Report Card*.[290] The remaining 44 states (AL, AK, AZ, AR, CA, CO, CT, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NY, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, WI, WY) and the District of Columbia do not have a state-mandated sex education program requirements, and also did not have such requirements in the 2000 *Report Card*.

(b) Does the state require that STD/HIV education be taught and that it include abstinence and other methods of prevention?[291] States can promote STD and HIV/AIDS education in public schools by requiring schools to offer STD/HIV education, and by enacting content requirements for these programs that include both abstinence and other methods of prevention such as the use of certain forms of contraception and the role of drug use in the transmission of the disease.[292] Fourteen states have mandated school-based STD/HIV education programs that include both contraception and abstinence. Of these, all 14 (AL, CA, DE, HI, KY, MI, NJ, NM, OK, OR, PA, RI, VT, WV) had the policy in last year's *Report Card*.[293] The remaining 36 states (AK, AZ, AR, CO, CT, FL, GA, ID, IL, IN, IA, KS, LA, ME, MD, MA, MN, MS, MO, MT, NE, NV, NH, NY, NC, ND, OH, SC, SD, TN, TX, UT, VA, WA, WI, WY) and the District of Columbia do not have state-mandated STD/HIV education requirements, and also did not have such requirements in the 2000 *Report Card*.

Key Health Conditions, Diseases and Causes of Death for Women

The *Report Card* includes status indicators for five areas: (1) key causes of death; (2) chronic conditions; (3) reproductive health; (4) mental health; and (5) violence against women. An index of policies addressing risk factors for these key health conditions is below.

Index Of Policies Addressing Risk Factors For Key Health Conditions

This index includes the policy indicators of particular importance for each of the conditions discussed in this section. Many of the overarching policies in the "Women's Access to Health Care Services" section apply to all of the conditions (e.g., policies increasing access to insurance or pharmaceuticals), and therefore are not listed repeatedly throughout this index.

Cardiovascular: Heart Disease/Stroke/High Blood Pressure
- Exercise
- Nutrition
- Smoking
- Diabetes-Related Services
- Diabetes Control Program
- Mental Health

Lung Cancer
- Smoking

Breast Cancer
- Direct Access to Obstetric, Gynecologic and Reproductive Health Services
- Breast and Cervical Cancer Treatment
- Mammograms
- Genetic Discrimination

Diabetes
- Diabetes-Related Services
- Diabetes Control Program
- Presumptive Eligibility for Pregnant Women
- Exercise
- Nutrition
- Smoking

Arthritis
- Arthritis Program
- Exercise
- Nutrition

Osteoporosis
- Osteoporosis Public Education
- Osteoporosis Screening
- Eating Disorders Parity
- Exercise
- Nutrition
- Smoking

HIV/AIDS
- AIDS Drug Assistance Program
- Sexuality and STD/HIV Education in Public Schools
- Presumptive Eligibility for Pregnant Women
- Family Planning
- Violence Against Women
- Chlamydia Screening

Reproductive Health
- Direct Access to Obstetric, Gynecologic and Reproductive Health Services
- Family Planning
- Maternity:
  - Medicaid Income Eligibility Expansions for Pregnant Women
  - Presumptive Eligibility for Pregnant Women
  - Continuity of Care
  - Hospital Stays After Childbirth
- Infertility Treatment Coverage
- Abortion Access
- STDs (including HIV/AIDS) and Cervical Cancer:
  - AIDS Drug Assistance Program
  - Pap Smears
  - Chlamydia Screening
  - Sexuality and STD/HIV Education in Public Schools
- Violence Against Women

Mental Health
- Mental Health Parity
- Eating Disorders Parity
- Depression Parity
- Exercise
- Violence Against Women

Violence Against Women
- Domestic Violence Health Care Provider Training
- Sexual Assault Health Care Provider, Police, Prosecutor Training
- Domestic Violence Anti-Discrimination in Insurance
- Mental Health
- Family Planning
- Abortion Access
- Gun Control

Key Causes of Death

Status Indicator: How many women die from heart disease? [294]

Heart disease is the leading cause of death for women in the United States, accounting for one-half of all women's deaths.[295] Women who have heart attacks are more likely to die from them within a year than are men.[296] The *Report Card's* benchmark is the Healthy People 2000 goal of reducing the number of women dying from heart disease to no more than 100 per 100,000 people (when applied to women).[297] Thirty-three states meet the benchmark and receive an "S": of these, 30 states (AK, AZ, CA, CO, CT, FL, HI, ID, IA, KS, ME, MD, MA, MN, MT, NE, NH, NJ, NM, ND, OR, RI, SD, TX, UT, VT, VA, WA, WI, WY) also met the benchmark in last year's *Report Card*; and three states (DE, IL, NC) improved from a "U". There are eight states that are within ten percent of the benchmark and receive a "U": of these, seven states (AR, IN, MI, MO, NV, OH, PA) also received a "U" last year; and one state (SC) improved from an "F". Nine states (AL, GA, KY, LA, MS, NY, OK, TN, WV) and the District of Columbia miss the benchmark by more than ten percent and receive an "F", as they did last year. The nation receives an "S", as it did last year. The *Report Card* examines policies that encourage preventive behaviors (for example, exercising, eating well, not smoking and reducing stress) because prevention is crucial to reducing women's deaths due to heart disease. Heart disease is discussed in greater detail in the *Report Card's* special chapter on women and cardiovascular health.

Status Indicator: How many women die from strokes? [298]

Strokes are the third leading cause of death among women in the United States.[299] An average of 24.5 women per 100,000 die from strokes each year.[300] The *Report Card's* benchmark is the Healthy People 2000 goal of reducing stroke deaths to no more than 20 per 100,000 (when applied to women).[301] Four states meet the benchmark and receive an "S": these four states (CT, MA, NY, RI) also met the benchmark in last year's *Report Card*. There are 12 states that are within ten percent of the benchmark and receive a "U": of these, five states (AZ, DE, FL, ME, NJ) also received a "U" last year; and seven states (MN, NE, NH, NM, SD, UT, VT) improved from an "F". Thirty-four states (AL, AK, AR, CA, CO, GA, HI, ID, IL, IN, IA, KS, KY, LA, MD, MI, MS, MO, MT, NV, NC, ND, OH, OK, OR, PA, SC, TN, TX, VA, WA, WV, WI, WY) and the District of Columbia miss the benchmark by more than ten percent and receive an "F", as they did last year. The nation receives an "F", as it did last year. Stroke is discussed in greater detail in a special *Report Card* chapter on women and cardiovascular health.

Status Indicator: How many women die from lung cancer? [302]

Nationally, lung cancer is the leading cause of cancer death for women and the second most common cause of death for women overall.[303] The incidence of lung cancer among women has increased 600 percent over the past 50 years.[304] The *Report Card's* benchmark is the Healthy People 2000 goal of reducing the lung cancer death rate among women to less than 27 per 100,000 women.[305] Twenty-five states and the District of Columbia meet the benchmark and receive an "S": these 25 states (AL, AZ, CA, CO, CT, GA, HI, ID, IA, KS, MN, MS, MT, NE, NM, NY, NC, ND, PA, SC, SD, TX, UT, WI, WY) and the District of Columbia also met the benchmark in last year's *Report Card*. There are 14 states that are within ten percent of the benchmark and receive a "U": of these, 13 states (AK, AR, FL, IL, LA, MA, MI, NJ, OK, TN, VT, VA, WA) also received a "U" last year; and one state (OH) improved from an "F". There are 11 states (DE, IN, KY, ME, MD, MO, NV, NH, OR, RI, WV) that miss the benchmark by more than ten percent and receive an "F", as they did last year. Since cigarette smoking is the primary risk factor for lung cancer, the *Report Card* includes policies that help women stop smoking, prevent them from starting or limit their exposure to second-hand smoke.

Status Indicator: How many women die from breast cancer? [306]

Breast cancer is the most common type of cancer for women in the United States, and the second leading cause of cancer death for women (following lung cancer).[307] It is the leading cause of cancer death for women age 25 to 54, and accounted for about 15 percent of cancer deaths among women nationwide in 2000.[308] The *Report Card's* benchmark is the Healthy People 2000 goal of reducing the number of women who die of breast cancer to 20.6 or less per 100,000 women.[309] Forty-three states meet the benchmark and receive an "S": of these, 36 states (AL, AK, AZ, AR, CA, CO, FL, GA, HI, ID, IN, IA, KS, KY, ME, MN, MO, MT, NE, NV, NH, NM, NC, ND, OK, OR, SC, SD, TN, TX, UT, VT, WA, WV, WI, WY) also met the benchmark in last year's *Report Card*; and seven states (CT, MA, MI, MS, OH, PA, VA) improved from a "U". There are seven states (DE, IL, LA, MD, NJ, NY, RI) that are within ten percent of the benchmark and receive a "U", as they did last year. The District of Columbia misses the benchmark by more than ten percent and receives an "F", as it did last year. The nation receives an "S", as it did last year. The Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program[310] provides mammograms and Pap smears to poor, older and minority uninsured women in each of the 50 states and the District of Columbia. Because early detection greatly improves a woman's likelihood of surviving breast cancer, the *Report Card* includes policies that provide access to mammography and other screening mechanisms, as well as policies that ensure women's access to treatment options. In addition, a new policy indicator component addresses state implementation of the new Medicaid breast and cervical cancer treatment option.

Chronic Conditions

Status Indicator: What percentage of women have high blood pressure? [311]

Controlling high blood pressure helps decrease the risk of developing heart disease and stroke. The *Report Card's* benchmark is the Healthy People 2010 goal of reducing the percentage of

people with high blood pressure to no more than 16 percent (when applied to women).[312] Only one state meets the benchmark and receives an "S"; this state (AZ) improved from a "U" in last year's *Report Card*. No state receives a "U" since none were within ten percent of the benchmark. The remaining 49 states and the District of Columbia miss the benchmark by more than ten percent and receive an "F", as they did last year. The nation also receives an "F", as it did last year. Policies affecting high blood pressure are similar to those affecting heart disease, discussed above and in the special chapter on women and cardiovascular health.

STATUS INDICATOR: How many women suffer from diabetes? [313]

Approximately six percent of women in the United States suffer from diabetes. No state has met the Healthy People 2000 goal of reducing the prevalence of diabetes cases to no more than 25 per 1000 people (when applied to women).[314] No state meets the benchmark and therefore no state receives an "S". No state is within ten percent of the benchmark and therefore no state receives a "U". All 50 states and the District of Columbia miss the benchmark by more than ten percent and receive an "F": of these, 49 states and the District of Columbia also received an "F" in last year's *Report Card*; and one state (AK) dropped from a "U". The nation receives an "F", as it did last year. Risk factors for diabetes include obesity, physical inactivity, poor nutrition, smoking and poor prenatal care.[315] The *Report Card* includes policies addressing these issues.

STATUS INDICATOR: How many women have been diagnosed with AIDS? [316]

In just over a decade, the percentage of all AIDS cases that are adult and adolescent women has more than tripled, from seven percent of all AIDS cases in 1985 to 23 percent of all AIDS cases in 1999.[317] The incidence of AIDS has increased most dramatically among women of color. In the United States, African American and Hispanic women account for more than three quarters of AIDS cases in women reported to date, even though they represent less than a quarter of all women.[318] The *Report Card's* benchmark is the Healthy People 2000 goal of having an AIDS incidence rate among women of no more than 13 per 100,000 women.[319] Forty-three states meet this benchmark and receive an "S": these 43 states (AL, AK, AZ, AR, CA, CO, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, PA, RI, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY) also met the benchmark in last

Leading Causes of Death For All Women Nationally by Age

Per 100,000 Women

All Ages	Diseases of the Heart	98.0
	Lung Cancer	26.9
	Cerebrovascular Disease	24.5
	Breast Cancer	20.2
	Accidents and Adverse Effects	17.7
	Chronic Obstructive Pulmonary Diseases	17.5
	Diabetes	12.5
	Pneumonia and Influenza	10.5
	Colorectal Cancer	10.2
	Ovarian Cancer	6.0
25 to 44	Accidents and Adverse Effects	16.1
	Diseases of the Heart	11.4
	HIV	9.4
	Breast Cancer	8.8
	Suicide	5.9
	Homicide	5.1
	Cerebrovascular Disease	4.0
	Lung Cancer	3.0
	Cirrhosis, Chronic Liver Disease	2.9
	Cervical Cancer	2.6
45 to 54	Diseases of the Heart	55.8
	Breast Cancer	39.4
	Lung Cancer	28.1
	Accidents and Adverse Effects	16.1
	Cerebrovascular Disease	15.4
	Diabetes	10.9
	Colorectal Cancer	9.7
	Ovarian Cancer	8.7
	Cirrhosis, Chronic Liver Disease	8.5
	Chronic Obstructive Pulmonary Diseases	8.4
55 to 64	Diseases of the Heart	189.6
	Lung Cancer	100.8
	Breast Cancer	67.5
	Chronic Obstructive Pulmonary Diseases	42.5
	Cerebrovascular Disease	39.0
	Diabetes	36.5
	Colorectal Cancer	29.3
	Ovarian Cancer	20.9
	Accidents and Adverse Effects	19.9
	Cirrhosis, Chronic Liver Disease	14.6
65 to 74	Diseases of the Heart	544.1
	Lung Cancer	204.5
	Chronic Obstructive Pulmonary Diseases	134.6
	Cerebrovascular Disease	120.9
	Breast Cancer	98.8
	Diabetes	82.6
	Colorectal Cancer	66.0
	Pneumonia and Influenza	42.9
	Ovarian Cancer	37.8
	Accidents and Adverse Effects	33.2
75 to 84	Diseases of the Heart	1670.1
	Cerebrovascular Disease	453.6
	Chronic Obstructive Pulmonary Diseases	279.2
	Lung Cancer	247.2
	Pneumonia and Influenza	188.1
	Diabetes	156.3
	Breast Cancer	138.0
	Colorectal Cancer	134.3
	Mental Disorders	97.3
	Accidents and Adverse Effects	81.0
85 and over	Diseases of the Heart	6119.5
	Cerebrovascular Disease	1646.0
	Pneumonia and Influenza	929.9
	Mental Disorders	596.0
	Chronic Obstructive Pulmonary Diseases	405.0
	Alzheimer's Disease	300.5
	Diabetes	279.8
	Colorectal Cancer	259.3
	Atherosclerosis	241.8
	Accidents and Adverse Effects	237.1

Source: National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data by State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM]

Note: The data in this chart are age-adjusted to the 1940 standard population and are three-year averages from 1995-1997, per 100,000 estimated population. Updated ranking information for leading causes of death data age-adjusted to the1940 standard age population were not available. Updated data for key causes of death (heart disease, stroke, lung cancer and breast cancer) as reported on the state and national *Report Card* pages are age-adjusted to the 1940 standard age population and are three-year averages from 1996 to 1998, per 100,000 estimated population, and were available through a NCHS special data request.

year's *Report Card*. One state (SC) is within ten percent of the benchmark and receives a "U", as it did last year. Six states and the District of Columbia miss the benchmark by more than ten percent and receive an "F": of these, five states (DE, FL, MD, NJ, NY) and the District of Columbia also received an "F" last year; and one state (CT) dropped from a "U." The nation receives an "S", as it did last year. The *Report Card* includes policies that help to prevent the spread of HIV/AIDS, including family planning programs and programs that educate young people about HIV prevention and that treat the disease by providing pharmaceutical assistance to people with HIV/AIDS.

Status Indicator: How many women have arthritis? [320]

Arthritis is the leading cause of disability in the United States, and an estimated 21.8 percent of women suffer from it.[321] Women are more likely than men to get arthritis, and it is the leading cause of limited activity among women age 40 and over.[322] Unfortunately, data collection on the prevalence of arthritis is sporadic and consistent data across the states are not available. Therefore, both the 2000 and the 2001 *Report Cards* only include national information about this disease. Research did not reveal any benchmark for arthritis, so the *Report Card* does not grade this indicator. Because of the positive impact that exercise and nutrition have on the pain and disability caused by arthritis, the *Report Card* includes policies that focus on these issues.

Status Indicator: How many women age 50 and over have osteoporosis? [323]

Nationally, 20 percent of women have osteoporosis. Osteoporosis can cause many health problems, particularly for older women, and it is a major risk factor for hip fracture.[324] Research did not reveal any reliable data on the prevalence of osteoporosis by state. Therefore, both the 2000 and 2001 *Report Cards* only include national information about this disease, and do not grade the states on this indicator. The data from last year's *Report Card* have not been updated. The nation fails to meet the Healthy People 2010 goal of reducing the number of osteoporosis cases to eight percent of adults age 50 and over (when applied to women).[325] Because the nation misses this benchmark by substantially more than ten percent, it receives an "F". While there is treatment, there is currently no cure for osteoporosis, making prevention an important priority. The *Report Card* includes policies encouraging preventive behavior (e.g., good nutrition, exercise, and no smoking) and public education, as well as policies that improve access to bone density screening.

Reproductive Health

Reproductive health is critical to women's health at every stage of a woman's life. The status indicators address women with chlamydia, unintended pregnancies and maternal mortality. These indicators were selected because they reflect a range of reproductive health services. The policy indicators include access to contraceptives, maternal care, infertility treatments, access to abortion services and prevention and treatment of sexually transmitted diseases, including HIV/AIDS.

Status Indicator: What percentage of women have chlamydia? [326]

Chlamydia is the most common bacterial sexually transmitted disease and is most prevalent among young women age 15 to 25.[327] Chlamydia is particularly dangerous, because it is often asymptomatic in women and can only be identified through screening.[328] Chlamydia infections can often lead to pelvic inflammatory disease (PID) which, in turn, can cause infertility, ectopic pregnancy and chronic pelvic pain.[329] The *Report Card's* benchmark is the Healthy People 2000 goal of reporting chlamydia prevalence of five percent or less among women tested at family planning clinics.[330] Twenty-two states meet the benchmark and receive an "S": of these, 19 states (AK, ID, IA, KS, KY, ME, MI, MN, MO, MT, NE, NY, ND, OR, SD, UT, VT, WV, WY) also met the benchmark in last year's *Report Card*; one state (CT) improved from a "U"; and two states (IN, MA) improved from an "F." There are six states that are within ten percent of the benchmark and receive a "U": of these, two states (AZ, CO) also received a "U" last year; and four states (FL, NM, OK, TN) improved from an "F". Twenty-two states and the District of Columbia miss the benchmark by more than ten percent and receive an "F": of these, 18 states (AL, AR, CA, DE, GA, IL, LA, MD, MS, NV, NH, NJ, NC, PA, SC, TX, VA, WA) also received an "F" last year; two states (HI, RI) dropped from an "S"; and two states (OH, WI) and the District of Columbia dropped from a "U." The nation receives a "U", as it did last year. The *Report Card* includes a policy on mandated insurance coverage for chlamydia screening.

Status Indicator: What percentage of pregnancies are unintended? [331]

In 1994, almost half of all pregnancies were unintended.[332] The proportion of unintended pregnancies varies greatly with women's age. The greatest percentage of unintended pregnancies occurs among teens under 18 (over 80 percent of pregnancies in this age group are unintended) and women age 40 and over (51 percent of pregnancies in this age group).[333] States do not uniformly collect data about unintended pregnancies, so both the 2000 and 2001 *Report Cards* only include national information about unintended pregnancies, and do not grade the states on this indicator. The data from last year's *Report Card* have not been updated. The Healthy People 2000 goal is to reduce unintended pregnancies to 30 percent or less of all pregnancies and, because the nation fails to meet this goal by more than ten percent, it receives an "F".[334]

Status Indicator: What is the maternal mortality ratio? [335]

Maternal mortality is a key indicator of health worldwide and reflects the ability of women to secure not only maternal health care services but other health care services as well. The World Health Organization estimates that 20 countries have reduced their maternal mortality levels to below the United States' level of 7.7 deaths per 100,000 live births.[336] African American women face a much higher risk than white women of dying from pregnancy-related conditions.[337] The data from last year's *Report Card* have not been updated. The *Report Card's* benchmark is the Healthy People 2000 goal of reducing the maternal mortality ratio

to no more than 3.3 per 100,000 live births.[338] Only three states (NH, MA, WA) meet this benchmark; they receive an "S". Three states (AK, NE, MT) have a maternal mortality of within ten percent of the goal; they receive a "U". The remaining 44 states (AL, AZ, AR, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MN, MS, MO, NV, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WV, WI, WY) and the District of Columbia fail to come within ten percent of the benchmark; they receive an "F". The nation receives an "F".

Mental Health

Status Indicator: What is the average number of mental health days during the past 30 days that were "not good" for women? [339]

One of the main themes in the first Surgeon General's report on mental health is that mental and physical health have a marked impact on each other and cannot be viewed separately.[340] Because good mental health is difficult to define (even though specific mental conditions may be identifiable), the indicator the *Report Card* uses reflects women's own sense of mental well-being by tracking their reporting of the average number of days during the past 30 days that their mental health was "not good." Women in Hawaii and Oklahoma have on average the lowest number of days when their mental health was "not good" (2.7 days). In the 2000 *Report Card*, women in Arizona had on average the lowest number of days that their mental health was "not good" (1.2 days). Women in Kentucky continue to have on average the highest number of such days (5.3 days). For the nation, the comparable figure was 3.8 days, slightly higher than that reported for the nation in the 2000 *Report Card* (3.5 days). Research did not uncover a standard benchmark about the acceptable number of "not good" mental health days, so the states are ranked and not graded on this indicator. The *Report Card* includes state policies addressing "mental health parity" that require private insurers to cover mental health conditions on the same basis as they cover physical health conditions.

Violence Against Women

Status Indicator: What percentage of women are victims of violence? [341]

Nationally, 55 percent of all women report having been raped and/or physically assaulted in their lifetime, affecting both their physical and mental health. Research did not reveal any consistent measures as a benchmark for this indicator, therefore, both the 2000 and 2001 *Report Cards* only include national information. The data from last year's *Report Card* have not been updated. Due to the serious lack of consistent and reliable data collected at the state level, the *Report Card* did not grade states on this indicator. The *Report Card* includes a number of policies addressing violence against women, including: health care provider protocols, training and screening on domestic violence; prohibitions on insurance discrimination against domestic violence victims; and sexual assault training for health care providers and police/prosecutors.

Living in a Healthy Community

The community in which a woman lives affects virtually all aspects of her health and well-being. The *Report Card* analyzes overall health, economic security, education, discrimination, gun control and environment.

Overall Health

Three measures of overall health of women are life expectancy, limited activity days and infant mortality rate.

Status Indicator: What is the average life expectancy for women? [342]

Life expectancy is a key indicator of health status worldwide. Women in Japan have the highest life expectancy (82.9 years), and the *Report Card* uses this benchmark to grade the states and the nation.[343] The data from last year's *Report Card* have not been updated. The United States misses this benchmark by four years (78.9 years), and has only the 19th highest life expectancy for women worldwide.[344] No individual state meets this benchmark. All 50 states are within ten percent of the benchmark (with a range of 81.3 years in Hawaii to 76.9 in Louisiana) and receive a "U". The District of Columbia misses the benchmark by more than ten percent (74.2 years); it receives an "F". The nation receives a "U".

Status Indicator: What is the average number of days in the past 30 during which women limited their activity? [345]

Illness affects all aspects of women's lives, including their ability to work, to care for their family, to participate in the community and to engage in daily activities. Research did not reveal any benchmark for the number of days out of the past 30 days during which women have to limit activity, so the *Report Card* ranks, but does not grade, the states on this indicator. The average number of days out of the past 30 that women report having to limit their usual activities due to poor physical or mental health is the lowest in South Dakota (2.6 days). In the 2000 *Report Card*, Alaska had the lowest average (2.6 days). Kentucky continues to have the highest number of days (6.1 days) that women report activity limitation in the past 30 days. For the nation as a whole, the comparable figure is 3.5 days, similar to last year's *Report Card* (3.6 days).

Status Indicator: What is the infant mortality rate? [346]

Infant mortality (i.e., infant deaths that occur within the first year of life) is a key indicator of health worldwide, reflecting the health not only of infants, but of the entire population.[347] Infant mortality is also an indicator of pregnant women's access to high quality primary care.[348] The *Report Card's* benchmark is the Healthy People 2000 goal of no more than seven infant deaths per 1,000 live births.[349] Twenty-four states meet the benchmark and receive an "S": of these, 17 (CA, CO, HI, ID, ME, MA, MN, NV, NH, NJ, NM, NY, OR, TX, UT, VT, WA) also met the benchmark in last year's *Report Card*; five (AK, CT, ND, RI, WI) improved from a "U"; and two (IA, WY) improved from an "F." There are nine states that are within ten percent of the benchmark and receive a "U": of these, five (AZ, FL, KY, MO, MT) also received a "U" last year; three (PA, SD, VA) improved from an "F" and one (KS) dropped from an "S." Seventeen states and the District of Columbia miss the benchmark by more than ten percent and receive an "F": of these, 15 (AL, AR, GA, IL, IN, LA, MD, MI, MS, NC, OH, OK, SC, TN, WV) and the District of Columbia also received an "F" last year; and two (DE, NE) dropped from a "U". The nation receives a "U", as it did last year.

Economic Security and Education

A woman's inability to afford health care services, health insurance, safe housing, nutritious food, and other basic necessities seriously compromises her health and well-being. Graduating from high school and college also significantly improves a woman's health and well-being, both by opening the door to greater economic security, and by providing the literacy skills necessary to navigate the health care system. The *Report Card* considers three critical measures of women's economic security and educational attainment: the number of women living in poverty, the wage gap between men and women, and the percentage of women graduating from high school. The *Report Card* reviews the following set of policies to measure the degree to which a state is addressing women's economic security: child support "pass-through"; child support collection rates; Supplemental Security Income; tax policies affecting poor families; and the minimum wage. Other state policies under the Temporary Assistance to Needy Families program vary so widely that they could not be compared.[350]

Status Indicator: What percentage of women age 18 and over live in poverty? [351]

On average, more than 12 percent of women live in poverty in the United States. In many states, nearly a quarter of women live in households below the federal poverty level.[352] As in the 2000 *Report Card*, no state has eradicated poverty (the *Report Card* benchmark for the states) and therefore no state receives an "S." There are 13 states that are within ten percent of the benchmark and receive a "U": of these, ten (AK, CO, CT, IN, MD, MN, NH, NJ, UT, WI) also received a "U" last year; and three states (IA, MA, VA) improved from an "F." Thirty-seven states and the District of Columbia miss the benchmark by more than ten percent and receive an "F": of these, 35 (AL, AZ, AR, CA, FL, GA, HI, ID, IL, KS, KY, LA, ME, MI, MS, MO, MT, NE, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, VT, WA, WV, WY) and the District of Columbia also received an "F" last year; and two (DE, NV) dropped from a "U." The nation receives an "F", as it did last year.

Status Indicator: What is the "wage gap" between male and female wage earners? [353]

The wage gap (the difference between men's wages and women's wages) is an important indicator of women's economic security, reflecting the particular economic hurdles women face that endanger their health and well-being. The *Report Card* uses a benchmark of women earning 100 percent of what men earn. As in the 2000 *Report Card*, all 50 states and the District of Columbia as well as the nation as a whole miss the benchmark by more than ten percent and receive an "F." The wage gap continues to be the smallest in the District of Columbia, where women earn 85.7 percent of what their male counterparts earn. The wage gap is the largest in Wyoming, where women earn less than 62.8 percent of what men earn. In the 2000 *Report Card*, the wage gap was the largest in Alabama and Oklahoma, where women earned less than 66 percent of what men earn. In this *Report Card*, women nationally earn 73.5 percent of what men earn, similar to that reported in the 2000 *Report Card* (72.3 percent).

Status Indicator: What percentage of women graduate from high school? [354]

Women without a high school degree have lower earnings, more difficulty securing health care, and are more likely to engage in substance abuse, experience unintended pregnancy and suffer other adverse health consequences.[355] The *Report Card* uses the Healthy People 2010 goal of 90 percent high school completion (when applied to women).[356] Only eight states meet the benchmark and receive an "S": of these, three (AK, UT, WA) also met the benchmark in last year's *Report Card*; and five (CO, MN, NE, SD, VT) improved from a "U". Thirty states and the District of Columbia are within ten percent of the benchmark and receive a "U": of these, 28 (AZ, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, ME, MD, MA, MI, MO, MT, NV, NH, NJ, NY, ND, OH, OK, OR, PA, VA, WI) and the District of Columbia also received a "U" last year; one (NM) improved from an "F" and one (WY) dropped from an "S". There are 12 states that miss the benchmark by more than ten percent and receive an "F": of these, ten (AL, AR, KY, LA, MS, RI, SC, TN, TX, WV) also received an "F" last year; and two (CA, NC) dropped from a "U." The nation receives a "U", as it did last year.

Policy Indicator: Does the state have effective policies to increase women's economic security?

The *Report Card* reviews the following measures that lend themselves to comparisons across states of policies and programs to improve women's economic security: (a) receipt of state-collected child support payments by families; (b) child support collection rates; (c) Supplemental Security Income; (d) amount of taxes poor families pay; and (e) the minimum wage. Two states

(CT, MA) have the composite policy because they have all of the policies. Nineteen states (AK, CA, DE, IL, ME, MI, NV, NJ, NM, NY, OR, PA, RI, SC, TX, VT, VA, WA, WI) have undertaken three or more significant aspects of these economic measures and therefore have a limited policy. Twenty-nine states (AL, AZ, AR, CO, FL, GA, HI, ID, IN, IA, KS, KY, LA, MD, MN, MS, MO, MT, NE, NH, NC, ND, OH, OK, SD, TN, UT, WV, WY) and the District of Columbia have only weak policies in place to improve women's economic security and therefore have a weak composite policy. Every state has at least one policy.

(a) Does the state allow families receiving Temporary Assistance to Needy Families (TANF) to keep some amount of the child support payments collected on their behalf?[357] Child support payments can make a substantial difference in the financial well-being of single mothers and their children.[358] Under federal law, families receiving welfare benefits (TANF) must assign their rights to child support payments to the state.[359] When a state collects child support on behalf of a TANF recipient, the state is permitted to keep the money to reimburse itself and the federal government for TANF assistance. States, however, have the option of allowing some of the child support payment to be "passed through" to the parent and child. Additionally, this amount of child support, usually $50, is "disregarded" in calculating the amount of TANF assistance the family receives, so the state does not count it as additional income to the family and reduce the amount of assistance by the amount of child support given to the family.[360] By providing this additional income, the "pass-through" allows low-income mothers and their children to better meet their daily needs, and also provides a greater incentive for noncustodial parents to pay child support since some of their child support payments will go to the child, rather than to the state. The data from last year's *Report Card* have not been updated. Twenty-three states (AK, CA, CT, DE, GA, IL, KS, ME, MA, MI, NV, NJ, NM, NY, PA, RI, SC, TN, TX, VT, VA, WV, WI) have a child support "pass-through" policy.[361] The remaining 27 states (AL, AZ, AR, CO, FL, HI, ID, IN, IA, KY, LA, MD, MN, MS, MO, MT, NE, NH, NC, ND, OH, OK, OR, SD, UT, WA, WY) and the District of Columbia have no policy.[362]

(b) What is the state's child support collection rate? [363] Low-income families are most likely to rely on the state for help in collecting child support.[364] States that collect some amount of child support in at least 40 percent of all cases are making an effort to advance the economic security of families. States that are collecting between 15 percent and 40 percent of all cases are making a limited effort. Those collecting less than 15 percent are making only a weak effort. Thirty-four states collected child support in at least 40 percent of the state's child support caseload: of these, five (ME, MN, NH, VT, WA) had the policy in last year's *Report Card*; 28 (AK, AR, CO, CT, DE, ID, IA, KS, MD, MA, MO, MT, NE, NJ, NY, NC, ND, OH, OK, OR, PA, SC, SD, UT, VA, WV, WI, WY) improved from a limited policy; and one (MI) improved from weak policy. There are 16 states that collected child support in 15 to 40 percent of all cases: of these, 13 (AL, AZ, CA, FL, GA, HI, KY, LA, MS, NV, RI, TN, TX) also had a limited policy last year; and three (IL, IN, NM) improved from a weak policy. Only the District of Columbia did not improve from having a weak policy in last year's *Report Card*. Every state had at least one policy. Advocates credit increased enforcement activity and legislative reforms with the improvement, but note that this still represents collection in only a fraction of all child support cases.[365]

(c) Does the state provide its own Supplemental Security Income to the elderly, blind and people with disabilities? [366] Women account for nearly 60 percent of the recipients of Supplemental Security Income (SSI).[367] States can supplement these payments to help these individuals meet their basic needs.[368] Forty-two states and the District of Columbia have additional supplemental security income: of these, 41 states (AL, AK, AZ, CA, CO, CT, FL, HI, ID, IL, IN, IA, KY, LA, ME, MD, MA, MI, MN, MO, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, UT, VT, VA, WA, WI, WY) and the District of Columbia had the policy in last year's *Report Card*; and one state (TX) improved from no policy. There are eight states (AR, DE, GA, KS, MS, MT, TN, WV) that do not have a policy and did not have one last year.

(d) What percentage of their income do the poorest 20 percent of families pay in state and local taxes? [369] States can structure their tax laws to alleviate low-income families' financial burdens. The *Report Card* examines the percentage of income the poorest 20 percent of families pay in state and local taxes, taking into account such mechanisms as state-level earned income tax credits.[370] States with lower tax burdens allow low-income families to use more of their incomes for necessities, including health care. The data from last year's *Report Card* have not been updated. The percentage of income that states require low-income families to pay in taxes ranged from 6.3 percent (DE) to 17.1 percent (WA).

(e) Does the state have a minimum wage that allows a family of three to reach the federal poverty threshold? [371] Women constitute approximately 60 percent of low wage earners nationwide.[372] The *2001 Report Card* identifies a minimum wage of $6.61 as allowing a family of three supported by a full-time, year-round, minimum wage earner to reach the federal poverty threshold.[373] States with a minimum wage that falls below $6.61, but above the federal minimum wage of $5.15,[374] have a limited policy. Those with a minimum wage that is at or below the federal minimum wage have a weak policy. States with no wage laws have no policy. Four states have a minimum wage above $6.61: of these, one (WA) had the policy last year; and three (CA, CT, MA) improved from a limited policy.[375] Six states and the District of Columbia set wages above the federal minimum wage but below $6.61: of these, five states (AK, DE, HI, RI, VT) and the District of Columbia had a limited policy in last year's *Report Card*; and one (OR) dropped from meeting the policy. Thirty-three states set the minimum wage at or below the federal minimum wage: of these, all (AR, CO, GA, ID, IL, IN, IA, KS, KY, ME, MD, MS, MN, MO, MT, NC, ND, NE, NV, NH, NJ, NM, NY, OH, OK, PA, SD, TX, UT, VA, WV, WI, WY) also had a weak policy last year. Seven

states (AL, AZ, FL, LA, MI, SC, TN) have no minimum wage, and had no such policy in last year's *Report Card*.[376]

Discrimination

Policy Indicator: Does the state have comprehensive anti-discrimination laws?

Discriminatory practices can affect women's health by creating barriers to health care services and health insurance, by creating stress that contributes to physical and mental health problems and by creating barriers to financial and educational achievement. This indicator examines state responses to two discriminatory practices where new legal protections are especially important: (a) employment discrimination based on sexual orientation, and (b) genetic discrimination. Nine states (CA, CT, MA, NV, NH, NJ, RI, VT, WI) have the composite policy because they have policies outlawing both sexual orientation and genetic discrimination. Eleven states (CO, DE, HI, IL, IA, MD, MN, MT, NM, NY, WA) have policies addressing both kinds of discrimination but at least one is in a weakened form and therefore have a limited composite policy. Twenty states (AL, AZ, FL, GA, IN, KS, KY, LA, ME, MI, MO, NC, OH, OK, OR, PA, SC, TN, TX, VA) and the District of Columbia have policies to address only one form of discrimination and have a weak composite policy. Ten states (AK, AR, ID, MS, NE, ND, SD, UT, WV, WY) do not have any policies prohibiting the two types of discrimination.[377]

(a) Does the state prohibit employment discrimination based on sexual orientation? [378] Employment discrimination affects women's health and well-being, not only because access to employment affects women's financial status, but because employment discrimination blocks one of the key avenues to health insurance. The federal government and the vast majority of states prohibit employment discrimination based on sex, race, religion, ethnicity, age and disability.[379] The federal government and most states do not, however, prohibit employment discrimination based on sexual orientation. Some states provide comprehensive protection by prohibiting employment discrimination based on sexual orientation in both public and private employment. Other states have a limited policy that prohibits discrimination against public employees while other states do not have any policy prohibiting discrimination. Twelve states and the District of Columbia have the policy: of these, 11 (CA, CT, HI, MA, MN, NV, NH, NJ, RI, VT, WI) and the District of Columbia also had the policy in last year's *Report Card*; and one (MD) improved from a limited policy. There are nine states that have a limited policy: of these, seven (CO, IL, IA, NM, NY, PA, WA) also had a limited policy in last year's *Report Card*; and two (DE, MT) improved from no policy. There are 28 states that do not have a policy: of these, all 28 (AL, AK, AZ, AR, FL, GA, ID, IN, KS, KY, LA, ME, MI, MS, MO, NE, NC, ND, OH, OK, OR, SC, SD, TN, TX, UT, VA, WV, WY) also did not have a policy in last year's *Report Card*.

(b) Does state law prohibit employment and health insurance discrimination based on genetic information? [380] Scientists are now beginning to identify genes that are related to specific diseases. These scientific advances may lead to discriminatory practices by both health insurance companies and employers looking to avoid the costs of potential illness. There is no comprehensive federal statute prohibiting genetic discrimination, although an Executive Order does bar such discrimination against federal employees.[381] Some states have a comprehensive policy prohibiting genetic discrimination in both health insurance and employment. Other states have a limited policy that prohibits discrimination in either health insurance or employment, and other states do not have any genetic anti-discrimination legislation. Twenty-one states have the policy: of these, 20 (AZ, CA, CT, DE, FL, IL, KS, ME, MI, MO, NV, NH, NJ, NC, OK, OR, RI, TX, VT, WI) also had the policy in last year's *Report Card*; and one (MA) improved from no policy. There are 18 states that have a limited policy: of these, all 18 (AL, CO, GA, HI, IN, IA, KY, LA, MD, MN, MT, NM, NY, OH, SC, TN, VA, WA) also had a limited policy last year. Eleven states and the District of Columbia do not have a policy: of these, all 11 (AK, AR, ID, MS, NE, ND, PA, SD, UT, WV, WY) and the District of Columbia did not have the policy last year.

Gun Control

Policy Indicator: Does the state have effective gun control laws?

Women lose their lives and survivors face serious health problems as a result of violent crimes.[382] In 1996, almost 5,000 women were killed with guns, and many more were injured.[383] States can enact a variety of policies to control guns, including restrictions: (a) requiring licensing and waiting periods; (b) requiring safe storage; and (c) prohibiting concealed handguns. No state has all three of these restrictions, although the District of Columbia bans handguns entirely and therefore has the composite policy.[384] Twelve states (CA, CT, HI, IL, IA, MA, MN, MO, NE, NJ, NY, WI) have a limited composite policy because they have adopted a strong combination of these restrictions. Sixteen states (AL, CO, DE, FL, KS, MD, MI, NV, NH, NM, NC, OH, RI, TX, VA, WA) have weaker or fewer gun restrictions and therefore have a weak composite policy. Twenty-two states (AK, AZ, AR, GA, ID, IN, KY, LA, ME, MS, MT, ND, OK, OR, PA, SC, SD, TN, UT, VT, WV, WY) do not have any of these restrictions. In each of the indicators below, because the District of Columbia has a complete ban on handguns, it is deemed to have each of the policies even though it does not explicitly have these separate restrictions.

(a) Does the state have statutes requiring handgun licensing or permits, and requiring waiting periods? [385] Licensing and waiting periods together reduce unauthorized and illegal access to guns and give local government the authority and time to conduct thorough background checks on potential handgun purchasers. States that adopt both licensing laws and mandatory waiting periods have the policy for this component. Some states have a limited policy by requiring licensing permits or waiting periods

but not both, and other states require neither. Eleven states have the policy: of these, ten (CT, HI, IL, IA, MA, MN, MO, NJ, NY, NC) also had this policy in last year's *Report Card*; and one (NE) improved from a limited policy. There are six states that have a limited policy: of these, five (CA, MD, MI, RI, WI) also had a limited policy last year; and one (WA) improved from no policy. The remaining 33 states do not have the policy: of these, 31 (AK, AZ, AR, CO, DE, GA, ID, IN, KS, KY, LA, ME, MS, MT, NV, NH, NM, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, VA, WV, WY) also did not have the policy in last year's *Report Card*; two (AL, FL) dropped from a limited policy.

(b) Does the state have statutes requiring "safe storage"? [386] Safe storage laws that require owners to either store guns in places that are inaccessible to children and/or use safety locks help protect women and their families from guns kept in homes. Some states have both safe storage and safety locks laws, other states have safe storage or safety locks laws but not both and therefore have a limited policy, and other states do not have either policy. Three states have the policy: of these, two (CA, CT) also had the policy in last year's *Report Card*; and one (NY) improved from no policy. There are 17 states that have a limited policy: of these, 13 (DE, FL, HI, IL, IA, MD, MN, NV, NC, RI, TX, VA, WI) also had the policy in last year's *Report Card*; two (MI, NH) improved from no policy; and two (MA, NJ) dropped from having the policy. The remaining 30 states do not have the policy: of these, 29 (AL, AK, AZ, AR, CO, GA, ID, IN, KS, KY, LA, ME, MS, MO, MT, NE, NM, ND, OH, OK, OR, SC, SD, TN, UT, VT, WA, WV, WY) also did not have the policy last year; and one (PA) dropped from having a limited policy.

(c) Does the state have statutes prohibiting the carrying of concealed weapons? [387] Limiting access to guns, including the ability to carry concealed weapons, can reduce the rate of violent crime.[388] While some states prohibit the carrying of concealed weapons, other states limit only a resident's ability to carry concealed weapons, and other states do not have any policies to limit the carrying of concealed weapons.[389] There has been no change in this indicator since the 2000 *Report Card*. Seven states (IL, KS, MO, NE, NM, OH, WI) have the policy. Fourteen states (AL, CA, CO, CT, DE, HI, IA, MD, MA, MI, MN, NJ, NY, RI) have a weak policy, and 29 states (AK, AZ, AR, FL, GA, ID, IN, KY, LA, ME, MS, MT, NV, NH, NC, ND, OK, OR, PA, SC, SD, TN, TX, UT, VT, VA, WA, WV, WY) do not have a policy.

Environment

Policy Indicator: Does the state have effective policies to address environmental health risks?

Exposure to hazardous agents in the air, water and soil contribute to illness, disability and death worldwide.[390] Two indicator components addressing this issue are: (a) state monitoring of six conditions that can be caused by environmental exposures, and (b) per capita spending on public transportation. The data for these components have not been updated since the 2000 *Report Card*. Four states (MS, MO, NM, WI) monitor at least five of these conditions. Nine states (AZ, CT, HI, IA, MD, MA, NJ, NY, UT) monitor three or four of these conditions. Twenty-four states (AR, CA, CO, DE, FL, IL, KS, KY, LA, ME, MI, MN, NE, NH, NC, OH, OK, OR, PA, RI, SC, TX, WA, WY) monitor one or two of these conditions. The remaining 13 states (AL, AK, GA, ID, IN, MT, NV, ND, SD, TN, VT, VA, WV) and the District of Columbia do not monitor any of these conditions. Public transportation spending ranges from approximately $675 in New Jersey to less than two dollars per urban resident in Mississippi.

(a) How well does the state monitor diseases or conditions that can be caused by exposures to environmental hazards? [391] Healthy People 2010 identified 15 significant health conditions caused by environmental factors that states should monitor. Among these are lead poisoning (for both adults and children), mercury poisoning, pesticide poisoning, carbon monoxide poisoning, acute chemical poisoning and asthma.[392] The *Report Card* selected these six conditions because they may be caused by environmental exposures women may react to or experience differently than do men.[393] Four states (MS, MO, NM, WI) monitor at least five of these conditions. Nine states (AZ, CT, HI, IA, MD, MA, NJ, NY, UT) have a limited policy because they monitor three or four of these conditions. Twenty-four states (AR, CA, CO, DE, FL, IL, KS, KY, LA, ME, MI, MN, NE, NH, NC, OH, OK, OR, PA, RI, SC, TX, WA, WY) have weak policies because they monitor one or two of these conditions. The remaining 13 states (AL, AK, GA, ID, IN, MT, NV, ND, SD, TN, VT, VA, WV) and the District of Columbia do not monitor any of these conditions.

(b) How much government money is spent (per urban resident) annually on public transit in the state? [394] A state's transportation policy contributes to a healthy community in important ways.[395] Effective public transit systems make it easier for low-income women to get to their health care providers and their workplaces, and also reduce hazardous air pollution by providing alternatives to automobiles.[396] The *Report Card* evaluates how much money (in federal, state and local funds) states spent annually per urban resident on public transit, averaged over a five-year period. Spending ranges from approximately $675 per urban resident in New Jersey to less than two dollars per urban resident in Mississippi.

Chapter III Notes

[1] ***Data Source: Women Without Health Insurance (%), 2000 (state race/ethnicity and age data 1997-1999).*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *2000 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000), Table 6.2, 17 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. Data for race/ethnicity and age at the state level are three-year averages from 1997 to 1999 and are age adjusted to the 2000 standard age population. National Center for Health Statistics, *State Health Statistics by Sex and Race/Ethnicity: Health Behavior and Risk Factor Tables* [Online]; Available: WWW URL: http://www.cdc.gov/nchs/statestatsbysexrace.htm, accessed 20 July 2001. EXPLANATION: This measure includes women age 18 to 64 in the non-institutionalized civilian population who report that they do not have health insurance. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico. Statistics on the percentage of women who are uninsured may vary depending on data source. Differences in survey methodology (e.g., sample size, weighting, etc., may yield different results. See Paul Fronstin, *Counting the Uninsured: A Comparison of National Surveys* (Washington, D.C.: Employee Benefit Research Institute, 2000). For more information, see http://www.ebri.org/ibex/ib225.htm. Jeanne Lambrew, *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (New York: The Commonwealth Fund, 2001), 25 [Online]; Available: WWW URL: http://www.cmwf.org/programs/insurance/lambrew_disparities_493.pdf, accessed 25 October 2001. The Henry J. Kaiser Family Foundation, "State Estimates of Health Insurance Coverage of Women Ages 18 to 64, 1997-1999," *Women's Health Policy Fact Sheet* (Menlo Park: The Henry J. Kaiser Family Foundation, 2001) [Online]; Available: WWW URL: http://www.kff.org/content/2001/1613/new1613.pdf, accessed 25 October 2001. The Henry J. Kaiser Family Foundation, "State Estimates of Health Insurance Coverage of Low-Income Women Ages 18 to 64, 1997-1999," *Women's Health Policy Fact Sheet* (Menlo Park: The Henry J. Kaiser Family Foundation, 2001) [Online]; Available: WWW URL: http://www.kff.org/content/2001/1613/new1613.pdf, accessed 25 October 2001. March of Dimes, Press Release, "While Number Improves for Children Millions of Women Still Lack Health Insurance," 16 October 2001 [Online]; Available: WWW URL: http://www.modimes.org/About2/PressReleases/2001/NumbersImprove.htm, accessed 24 October 2001.

[2] Jeanne M. Lambrew, *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (New York: The Commonwealth Fund, 2001), 4.

[3] Jeanne M. Lambrew, *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (New York: The Commonwealth Fund, 2001), 1-2, 4-5. See also Roberta Wyn and others, *Falling Through the Cracks: Health Insurance Coverage for Low-income Women* (Los Angeles: The Henry J. Kaiser Family Foundation, 2001).

[4] U.S. Department of Health and Human Services, *Healthy People* 2010, 2nd ed. (Washington, D.C.: U.S. Department of Health and Human Services, 2000), Objective 1-1 [Online]; Available: WWW URL: http://www.health.gov/healthypeople, accessed 30 September 2001 (hereafter *"Healthy People 2010"*). When the *Report Card* refers to a Healthy People objective, only the objective number (not page number) is cited. However, when the *Report Card* cites the *Healthy People* text, page numbers are included.

[5] Medicaid National Summary Statistics, *Medicaid Recipients as a Percentage of Population by Sex* (Washington, D.C.: Health Care Financing Administration, 1998) [Online]; Available: WWW URL: http://www.hcfa.gov/medicaid/msis/2082-10.htm, accessed 10 October 2001 (1998 figures; was 15 percent in 1996 and 1997).

[6] 42 U.S.C. §§ 1396-1396v; 42 C.F.R. Ch. IV; 45 C.F.R. Subtitle A; see also HCFA, *Medicaid Eligibility*, 2 August 1999 [Online]; Available: WWW URL: http://www.hcfa.gov/medicaid/meligib.htm, accessed 20 August 2001.

[7] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured and Their Access to Health Care," May 2000 [Online]; Available: WWW URL: http://www.kff.org/content/2000/1420/pub%201420.pdf, accessed 20 August 2001. The federal poverty level for the purposes of this indicator is the U.S. Department of Health and Human Services' federal poverty guideline and is the federal government's working definition of poverty that is used to set the income standard for Medicaid eligibility for certain categories of beneficiaries, and is updated every year. Kaiser Commission on Medicaid Basics, *Medicaid: A Primer* (Washington, D.C.: Kaiser Commission, 1999), 12.

[8] ***Data Source: Pregnant Women Medicaid Eligibility Incomes (% FPL), 2000.*** Emily Cornell, "Maternal and Child Health (MCH) Update: States Have Expanded Eligibility and Increased Access to Health Care for Pregnant Women and Children" National Governor's Association Report (22 February 2001). EXPLANATION: The federal poverty level (FPL) here refers to the 2000 federal poverty guideline.

[9] *Healthy People 2010*, 16-28 (reporting a rise in the number of women entering prenatal care in the first trimester from 75.8 percent in 1990 to 82.5 percent in 1997).

[10] 42 C.F.R. § 435.904 (matching fund). Last year's *Report Card* did not clearly state the definition of this limited policy category. The 2001 *Report Card*, however, clarifies that states with eligibility levels above 133 percent and up to and including 185 percent are considered to have a limited policy. There are no states with eligibility levels higher than 185 percent and lower than 200 percent of FPL.

[11] Although the 2000 *Report Card* accurately categorized Missouri in the indicator description (p. 126) as having a limited policy, the chart on page 116 of the 2000 *Report Card* incorrectly lists Missouri as having a weak policy. In addition, the source for the 2000 *Report Card* incorrectly reported that Tennessee's Medicaid eligibility level for pregnant women was 400 percent; in fact, the level was also 185 percent for that year, so Tennessee had a limited policy in both *Report Cards*. Rules of the Tennessee Department of Human Services, Division of Medical Services, ch. 1240-3-2-.02(k)(most recently revised July 1997); Tennessee Department of Human Services, "Chapter 10: Families and Children," in II *Medical Assistance Manual* (most recently revised December 1994), 6.

[12] 42 C.F.R. § 435.904 (description of federal minimum).

[13] ***Data Source: Single Parents Medicaid Eligibility (% FPL), 2001.*** Center for Budget and Policy Priorities (CBBP) table, "How Much Can a Working Parent with Two Children Who is Applying for Publicly-funded Coverage Earn and Still Be Eligible, Spring 2001," unpublished report based on a CBPP directed survey of state officials concerning eligibility policies and procedures effective in July 2000 in Medicaid and other publicly-financed programs available to low-income families with children. Where appropriate, updates to the data have been made such that figures for states' earnings thresholds reflect policies in place as of Spring 2001. Data were analyzed in consultation with Matt Broaddus, CBPP, June-September 2001. EXPLANATION: The 2001 *Report Card* identifies the federal poverty guideline and earnings threshold data that are current through Spring 2001. The 2000 *Report Card* incorrectly noted the earnings threshold data were current as of November 1999; the earning threshold data were actually current as of 2000. The federal poverty level (FPL) here refers to the federal poverty guideline.

[14] Jocelyn Guyer and others, *Taking the Next Step: States Can Now Expand Health Coverage to Low-Income Working Parents Through Medicaid* (Washington, D.C.: Center on Budget and Policy Priorities, 1998), 1.

[15] The *Report Card* considers states to have a limited policy if they raise the eligibility requirement beyond 74 percent (but below 200 percent) of FPL, because the federal minimum income at which states must cover single parents under Medicaid varies among states. Federal Medicaid law generally requires states to cover the aged and disabled who are eligible for Supplemental Security Income (SSI). 42 C.F.R. § 435.120 (except for certain states called 209(b) states, 42 C.F.R. § 435.121). In 2001, the income threshold for SSI, and therefore for Medicaid coverage, was approximately 74 percent of the federal poverty level (FPL). See Social Security Administration, "A Desktop Guide to SSI Eligibility Requirements" (SSA Pub. No. 05-11001)[Online]; Available: WWW URL: http://www.ssa.gov/pubs/11001.html, accessed 8 October 2001. FPL refers to the federal poverty guidelines for 2001, as reported in "Annual Update of the HHS Poverty Guidelines," *Federal Register* 66 (Feb. 16, 2001), 10695-10697. Based on inaccurate information from the 2000 *Report Card* source, Connecticut was described as having a limited policy when it should have been placed in the "no policy" category. Data analyzed in conversation with Matt Broaddus, CBBP, 10 October 2001.

[16] The 2001 *Report Card* includes New York in this category because New York's Medically Needy program covers single parents with incomes above 74 percent of FPL. The 2000 *Report Card* source did not include Medically Needy data so the 2000 *Report Card* considered New York to not have expanded coverage for single parents above 74 percent FPL.

[17] ***Data Source: Aged and Disabled Medicaid Eligibility Incomes (% FPL), 2001.*** Families USA, "Could Your State Do More To Expand Medicaid for Seniors and Adults with Disabilities?," forthcoming publication (data from April 2001 survey). EXPLANATION: To obtain the eligibility levels as a percentage of the federal poverty level for this indicator, the highest eligibility income reported for each state (not including 1115 waivers) is divided by the federal poverty guideline for 2001 ($716 a month); Alaska and Hawaii have their own separate poverty guidelines, which for 2001 were $894 and $825 respectively. *Federal Register* 66 (February 16, 2001), 10695-10697. "Aged" is defined as 65 or older and "disability" is defined as "a physical or mental impairment that keeps a person from performing any 'substantial' work, and is expected to last 12 months or result in death." 42 U.S.C. §§ 1396d(a)(iii), 1396d(a)(viii). Because no state covers the aged and disabled at 200 percent of FPL, and because 100 percent of FPL is generally the highest level at which states have the option to cover aged and disabled individuals and still receive matching funds (42 U.S.C.§§ 1396a(a)(10)(A)(ii)(X), 1396a(m)), the *Report Card* considers states that cover up to and including 100 percent of FPL for the aged and disabled to have the *Report Card* policy. See Brian K. Gruen and others, *State Usage of Medicaid Coverage Options for Aged, Blind and Disabled People* (Washington, D.C.: The Urban Institute, 1999), 5-6. Although it is less common, states also can cover even higher than 100 percent if they disregard income, 42 C.F.R. § 435.601, as Mississippi and California do. To determine how the states were categorized, it was necessary to divide the state eligibility numbers by the 2001 federal poverty guidelines. When a state took the up to 100 percent OBRA option (Florida is at 90 percent) (column one of the Families USA chart), this is the number used to calculate for the categorization. If that number is not available, the *Report Card* uses the higher of column two (Medically Needy) or 3 (SSI + Supplemental). This year, column two was used only for New York, Vermont and Washington. OBRA gives states the option of covering individuals up to 100 percent. Some states have selected this option. Other states that have not selected this option may also have the policy, but have elected some other way to cover individuals at higher income levels. To assign each state a category, the *Report Card* used the highest dollar amount that a particular state will allow an individual to have as income and still receive Medicaid, divided that number by the SSI 2001 Benefit ($531) to arrive at the percent of poverty up to which an individual is covered.

[18] Andy Schneider and others, *Medicaid Eligibility for Individuals with Disabilities* (Washington D.C.: Kaiser Commission on the Uninsured, 1999), 1, 3, 5. States also vary significantly in their participation in the Qualified Medicare Beneficiary (QMB) program, a federal program usually operated through state Medicaid programs that helps protect poor Medicare beneficiaries from Medicare's out-of-pocket health care costs. Recent estimates are that almost half of those eligible for these benefits are not participating. See Patricia B. Nemore, *Variations in State Medicaid Buy-in Practices for Low-Income Beneficiaries: A 1999 Update* (Washington, D.C.: Henry J. Kaiser Family Foundation, 1999).

[19] As noted above, except in limited circumstances, 100 percent of FPL is the highest income eligibility level at which states can get federal matching funds. For seniors with income sources other than SSI and state supplements, income guidelines for 209(b) states (CT, HI, IL, IN, MN, MO, NH, ND, OH, OK, VA) may be more restrictive and not automatically provide coverage for all SSI recipients. Families USA, "Could Your State Do More to Expand Medicaid for Seniors and Adults With Disabilities?," (forthcoming). Arizona operates its Medicaid program using an 1115 waiver. Three states (OR, TN, VT) also have 1115 waivers that increase the eligibility higher than 100 percent of FPL. However, because the waivers in these three states are very restrictive (e.g., they apply only to those who do not have Medicare or those who are uninsurable), the *Report Card* does not include these figures as their eligibility guidelines. The *Report Card* does however, use Arizona's 1115 waiver eligibility guideline, since it applies to its entire Medicaid program and is not similarly restricted. Illinois is phasing to 100 percent FPL by 2002.

[20] Federal Medicaid law generally requires states to cover the aged and disabled who are eligible for Supplemental Security Income (SSI). 42 C.F.R. § 435.120 (except for certain states called 209(b) states, 42 C.F.R § 435.121).

[21] Rhode Island is included in this list because the limit ($715.83) was rounded to $716.

[22] Connecticut was inaccurately categorized as having the policy in last year's *Report Card* when it had a limited policy. Connecticut has a limited policy because it only expands the eligibility to 100 percent for some people (e.g., some that receive SSI supplements based on high housing costs), as authorized by 42 C.F.R. § 435.121.

[23] HCFA, *Supporting Families in Transition: A Guide to Expanding Health Coverage in Post-Welfare Reform* (Washington, D.C.: HFCA, 1999), 1. Although welfare reforms in 1996 ended welfare eligibility for some recipients, it allowed some of these individuals to maintain their Medicaid eligibility. However, Medicaid-eligible individuals who are not welfare beneficiaries are often erroneously denied participation in the program or are not aware that they remain Medicaid-eligible. Liz Schott and others, *Assuring That Eligible Families Receive Medicaid When TANF Assistance is Denied or Terminated* (Washington, D.C.: Center on Budget and Policy Priorities, 1998); Letter from Timothy Westmoreland, HCFA Director, to State Medicaid Directors, 7 April 2000 [Online]; Available: WWW URL: http://www.hcfa.gov/medicaid/smd40700.htm, accessed 22 August 2001 (urging states to identify individuals who have been terminated improperly and to reinstate them).

[24] ***Data Source: 100-Hour Rule for Two-Parent Families, 2000.*** Unpublished report based on a Center For Budget and Policy Priorities (CBPP) directed survey of state officials concerning eligibility policies and procedures effective in July 2000 in Medicaid and other publicly-financed programs available to low-income families with children.

[25] HCFA, *Supporting Families in Transition: A Guide to Expanding Health Coverage in Post-Welfare Reform* (Washington, D.C.: HFCA, 1999), 7; Jocelyn Guyer and

others, *Taking the Next Step: States Can Now Expand Health Coverage to Low-Income Working Parents Through Medicaid* (Washington, D.C.: Center on Budget and Policy Priorities, 1998). The U.S. Department of Health and Human Services issued a regulation on 7 August 1998 eliminating this restriction that was a remnant of the old welfare system. "Medicaid and Title IX-E Programs; Revision to the Definition of an Unemployed Parent," *Federal Register* 63 (1998), 42270 (codified at 45 C.F.R. § 233.100).

[26] Five states (HI, IL, MA, NE, TX) did not have family coverage categories in July 2000, and so the presence or absence of the 100-hour rule is noted for the state's Medicaid program instead of coverage of two-parent families.

[27] Two states (CA, KY) have dropped some aspects of the 100-hour rule, but retain other substantial 100-hour barriers, and therefore the *Report Card* considers them to have a harmful policy. In California, working two-parent families with children applying for coverage may be deemed ineligible solely on the basis of failure to meet the 100-hour rule. Families income-eligible for Medi-Cal as a result of income disregards applied for child support receipt and child care expenses may still be subject to the 100-hour rule if their income after a $90 earnings disregard is above 100 percent of the federal poverty guideline. Kentucky has dropped the 100-hour rule for current recipients of Medicaid but retains the rule for new applicants. Data analyzed in conversation with Matt Broaddus, CBBP, 10 October 2001.

[28] ***Data Source: Presumptive Eligibility for Pregnant Women, 2000.*** National Governors Association, Table 4, "Presumptive Eligibility for Pregnant Women in Medicaid and Children in Medicaid and SCHIP, October 1, 2000," in Emily V. Cornell, *Maternal and Child Health (MCH) Update: States Have Expanded Eligibility and Increased Access to Health Care for Pregnant Women and Children* 22 February 2001 [Online]: Available: WWW URL: http://www.nga.org/cda/files/MCHUPDATE2000.pdf, accessed 22 August 2001.

[29] 42 U.S.C. § 1396r-1 (states may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period); see also HCFA, "Optional Coverage of Categorically Needy Groups," in *State Medicaid Manual* § 3500.2, 1997 [Online]; Available: WWW URL: http://www.hcfa.gov/medicaid/wrcvi.htm, accessed 2 October 2001.

[30] ***Data Source: Joint Parent/Child Simplified Mail-In Application, 1999.*** Memorandum from Laura Cox, Center on Budget and Policy Priorities, 5 October 1999.

[31] Donna Cohen Ross and others, *Free & Low-Cost Health Insurance: Children You Know are Missing Out* (Washington, D.C.: Center on Budget and Policy Priorities, 1998), 17-18; Conversation with Donna Cohen Ross, Center on Budget and Policy Priorities, May 2000, regarding the cumulative impact of allowing parents to apply with their children, the simplified application, and the mail-in application process.

[32] The *Report Card* does not consider states to have the policy if they allow simplified mail-in applications for children but do not allow parents to apply jointly with children.

[33] ***Data Source: Assets Test for Parents, 2000.*** Center on Budget and Policy Priorities (CBBP), unpublished report based on a CBPP directed survey of state officials concerning eligibility policies and procedures effective in July 2000 in Medicaid and other publicly-financed programs available to low-income families with children.

[34] 42 U.S.C. § 1396u-1(b)(2)(c).

[35] Center on Budget and Policy Priorities, *Steps States Can Take to Facilitate Medicaid Enrollment of Children* (Washington, D.C.: Center on Budget and Policy Priorities, 1998).

[36] ***Data Source: Other State Insurance, 2001.*** Families USA, "State Programs to Provide Health Coverage to Adults Without Regard to Disability," unpublished data, June 2001. EXPLANATION: Last year, the *Report Card* listed eight states (AK, CT, KS, MD, MO, ND, UT, WI) as having weak policies because their programs either provided insurance coverage to a limited group of adults not otherwise covered by publicly funded health insurance (e.g., disabled individuals who do not otherwise qualify for Medicare or Medicaid) or provided a narrower set of services to individuals at or below a specific income level. Because the policies of these states were so narrow, the 2001 *Report Card* eliminates the weak policy category and includes those states that fall into the category among the states that have no policy.

[37] Federal poverty level here refers to the 2001 federal poverty guideline.

[38] ***Data Source: People in Medically Underserved Areas (%), 2000.*** American Association of Retired Persons (AARP), *Reforming the Health Care System: State Profiles, 2000* (Washington, D.C.: AARP, 2000). EXPLANATION: The term "underserved" was developed by the Division of Shortage Designation within the U.S. Health Resources and Services Administration (HRSA), Bureau of Primary Health Care, and indicates a population-to-practitioner ratio of greater than 2,000:1. The measure applies to both women and men, and assumes that in states where there are fewer practicing primary care physicians, there is reduced access to primary care services. "Practitioner" or "primary care physician" here means all allopathic (M.D.) or osteopathic (D.O.) practitioners who provide primary care services, and does not focus on their discipline or specialty. The measure is calculated based on Bureau of Primary Health Care data adjusted by the U.S. Bureau of the Census, Population Estimates. *National:* The national figure calculated by AARP Public Policy Institute includes 50 states and the District of Columbia.

[39] American Association of Retired Persons (AARP), *Reforming the Health Care System: State Profiles, 2000* (Washington, D.C.: AARP, 2000), 9.

[40] *Healthy People 2010*, 1-7, 1-8.

[41] ***Data Source: Safety Net Services, 2001.*** National Association of Community Health Centers (NACHC), 2001. EXPLANATION: Data for two states (LA, RI) were still not available at the time the 2001 *Report Card* research was completed. Last year's *Report Card* included an additional component of the policy indicator for safety net services, namely whether a state continued to reimburse Federally Qualified Health Centers (FQHCs) for 100 percent of the cost of serving Medicaid recipients even though changes in federal law in 1997 allowed states to reduce their payment levels to the centers. In December 2000, Congress passed new legislation, codified in 42 U.S.C. § 1396a(aa), changing the way safety net providers like FQHCs are reimbursed under Medicaid from a cost-based reimbursement methodology to a prospective payment system. Under federal guidelines, states have until December 31, 2001 to implement the new prospective payment system methodology. Therefore, it is too early to determine what type of state policies under the new Medicaid payment system most effectively support safety net services. Communication from the National Association of Community Health Centers, Inc., 3 October 2001.

[42] Sara Rosenbaum and others, "State Funding of Comprehensive Primary Medical Care Service Programs for Medically Underserved Populations," *American Journal of Public Health* 88 (March 1998), 357; Conversation with Heather Mizeur, National Association of Community Health Centers, February 2000.

[43] Sara Rosenbaum and others, "State Funding of Comprehensive Primary Medical Care Service Programs for Medically Underserved Populations," *American Journal of Public Health* 88 (March 1998), 357.

[44] "Birth and Adoption Unemployment Compensation," *Federal Register* 65 (June 13, 2000), 37210- 37301, codified at 20 CF.R. Part 604; Donna Lenhoff and Elana Tyrangiel, "Paying Mom: Now that States Can Grant Unemployment Benefits to New Parents, they Should," National Partnership for Women and Families, 7 August 2000 [Online]; Available: WWW URL: http://www.nationalpartnership.org, accessed 8 July 2001.

[45] ***Data Source: Family and Medical Leave, 1999.*** National Partnership for Women and Families, "Work & Families: State Family Leave Laws That Are More Expansive than the Federal Family and Medical Leave Act," 25 March 1999 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/statelaw.htm, accessed 2 October 2001.

[46] The Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 *et seq.*, applies to businesses with 50 or more employees and requires them to allow workers to take up to 12 weeks of unpaid leave a year to care for a newborn, newly-adopted child, seriously ill child, spouse, or parent, or to recover from their own serious health conditions; National Partnership for Women and Families, "Family Leave Initiative," 1998 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/initiativemain.htm, accessed 29 August 2001.

[47] The following are ways that this source measures state expansions upon the FMLA: (1) States that have comprehensive or less than comprehensive family and medical leave laws that apply to employers for fewer than 50 employees; (2) states that allow leave for participation in children's educational activities; (3) states that require leave for family medical needs not covered by the federal law; (4) states that use a more expansive definition of a "family member" whose illness may justify leave; and (5) states that provide longer periods of family and medical leave. While there are some states that specifically provide additional family or medical leave benefits to their state employees, the state indicator measures only those states with laws applying to private sector *and* state employees.

[48] ***Data Source: Temporary Disability Insurance, 2001.*** National Partnership for Women and Families, "Chart: Temporary Disability Insurance Policies," 23 November 1999 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/tdichart.htm, accessed 9 October 2001. Data updated through 2001 in conversation with Lissa Bell, Senior Policy Associate, National Partnership for Women and Families, August 2001.

[49] National Partnership for Women and Families, "State Family-Leave Income Initiatives: Making Family Leave More Affordable," March 2001 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/flinsur.htm, accessed 29 August 2001.

[50] National Partnership for Women and Families, "State Family-Leave Income Initiatives: Making Family Leave More Affordable," March 2001 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/flinsur.htm, accessed 29 August 2001. Limitations include: women with disabilities arising from pregnancy or childbirth can receive TDI, but only through the period of maternal disability, not for any leave taken beyond that period. Furthermore, TDI does not cover leave to care for a newly adopted child, paternity leave, or leave to care for seriously ill family members. *Ibid.*

[51] The maximum benefits and maximum length of benefits vary among these five states. California leads the five with a maximum of 52 weeks per year allowed and a maximum amount of $490 per week. National Partnership for Women and Families, "Chart: State Temporary Disability Insurance Policies," 23 November 1999 [Online]; Available: WWW URL: http://www.nationalpartnership.org/workandfamily/fmleave/tdichart.htm, accessed 28 August 2001.

[52] Deborah Lewis-Idema and others, *Health Care Access and Coverage for Women* (New York: The Commonwealth Fund, 1999), 13. *See also* Gabel, J. and others, "Managed Care in Transition" *New England Journal of Medicine* 344 (5 April 2001), 1087-1092 (in 1999, 92 percent of enrollment in health plans among persons with employer-sponsored coverage was in some type of managed care organization).

[53] Deborah Lewis-Idema and others, *Health Care Access and Coverage for Women* (New York: The Commonwealth Fund, 1999), 16.

[54] ***Data Source: Direct Access, 2001.*** National Conference of State Legislatures (NCSL), "Direct Access," 3 July 2001 [Online]; Available: WWW URL: www.hpts.org/HPTS97/home.nsf, accessed 10 July 2001. Data for the District of Columbia were updated for the *Report Card* by the National Conference of State Legislatures Health Policy Tracking Service, 23 July 2001.

[55] This indicator recognizes managed care programs that provide "direct access" if a female enrollee does not select the OB/GYN as her primary care provider.

[56] ***Data Source: Continuity of Care, 2001.*** National Conference of State Legislatures (NCSL), "Continuity of Care," 3 July 2001 [Online]; Available: WWW URL: www.hpts.org/HPTS97/home.nsf, accessed 10 July 2001. Data for the District of Columbia were updated for the *Report Card* by the National Conference of State Legislatures Health Policy Tracking Service, 23 July 2001.

[57] Optimally, managed care companies would be required to cover continued care with the provider for pregnant women regardless of when during the pregnancy the services began. However, the *Report Card* treats states that require continued coverage if services begin in the second trimester as having the policy discussed, since this coverage is an important first step.

[58] Although Arkansas and Minnesota do not have specific pregnancy stipulations, the *Report Card* interprets "current course of treatment" or "enrollees with special needs" to imply pregnant women are covered under law. South Dakota was inaccurately assessed and graded in the 2000 *Report Card* as having a limited policy; it actually met the 2000 *Report Card* policy requirements. Consideration of the law (SB No. 236) passed in 1999 confirms the state had the policy.

[59] Iowa has a limited policy because the law only applies to people with a terminal illness. Maryland was inaccurately categorized in the 2000 *Report Card* as having no policy, it actually had a limited policy. Michigan has a limited policy because the law only applies to people with a terminal illness. South Carolina was inaccurately assessed and graded in the 2000 *Report Card* as having no policy, it actually had a limited policy.

[60] ***Data Source: Clinical Trials, 2001.*** National Conference of State Legislatures (NCSL), "Clinical Trials," 23 July 2001 [Online]; Available: WWW URL: www.hpts.org/HPTS97/home.nsf, accessed 2 August 2001. Data for the District of Columbia were updated by the National Conference of State Legislatures Health Policy Tracking Service for the *Report Card*, 23 July 2001.

[61] Illinois was inaccurately described in the 2000 *Report Card* as having the policy; it actually had a weak policy because it only mandates insurers to *offer* coverage.

[62] Georgia requires private insurers to cover clinical trials only for children under age 19.

[63] ***Data Source: External Review, 2001.*** Families USA Foundation, "State Managed Care Patient Protections," March 2001. National Conference of State Legislatures, "Consumer Grievance Procedures: Internal and Independent Appeals," 3 July 2001 [Online]; Available: WWW URL: www.hpts.org/HPTS97/home.nsf, accessed 23 July 2001.

[64] The *Report Card* does not consider five states (IL, OR, NC, UT, WV) as having external review procedures, because their reviews are only for limited circumstances (such as only for investigational or experimental procedures) or because they allow employees of the managed care plan to be panel reviewers.

[65] ***Data Source: Linguistic Access, 1997.*** Jane Perkins and others, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities,* National Health Law Program (NHeLP) (Los Angeles: Kaiser Family Foundation, 1998). Categorized with the assistance of Jane Perkins. EXPLANATION: Considerations included level of specific guidance provided by state, variety of settings included, general statements endorsing goal of

linguistic access, enforcement provisions, and mandatory or optional nature of statutes and regulations. Sources reviewed included administrative regulations regarding hearings on Medicaid and Medicare eligibility.

[66] Jane Perkins and others, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities, National Health Law Program* (Los Angeles: Kaiser Family Foundation, 1998), ix, 191.

[67] ***Data Source: First Trimester Prenatal Care (%), 1999.*** S.J. Ventura and others, "Births: Final Data for 1999: National Center for Health Statistics," *National Vital Statistics Report* 49 (17 April 2001), 64 Table 34. EXPLANATION: This measure is the percentage of mothers who reported on their child's birth certificate that they received prenatal care in the first trimester of pregnancy. *National:* The national number includes all 50 states and the District of Columbia.

[68] *Healthy People 2010*, 16-28.

[69] U.S. Department of Health and Human Services, *Healthy People 2000 Review, 1997* (Hyattsville: U.S. Public Health Service, 1997), Objective 14 (hereafter *"Healthy People 2000"*).

[70] ***Data Source: Women In County Without Abortion Provider (%), 1996.*** Stanley K. Henshaw, "Abortion Incidence and Services in the United States, 1995-1996," *Family Planning Perspectives* 30 (November/December 1998), 263-270, 287. EXPLANATION: This measure includes women age 15 to 44 living in a county without an abortion provider (defined as a place where abortions are performed, e.g., a hospital, clinic, or physician's office). If an organization offers abortion services at more than one location, each service site is counted as a provider. The number of providers is different than the number of physicians who perform abortions, because one physician could be responsible for services in several facilities, and several physicians could perform abortions in a single setting. An abortion is defined as "any procedure, including menstrual extraction and menstrual regulation, intended to terminate a pregnancy." This is the only indicator in the *Report Card* for which the benchmark (the percentage of women living in a county without an obstetrician-gynecologist) is unique to each state. Thus, the grades are based on the state's benchmark and the ranks are based on the difference between the indicator (the percentage of women living in a county without an abortion provider) and the benchmark (the percentage of women living in a county without an obstetrician/gynecologist) for each state. Benchmark data are not available for Alaska, therefore, no state grade or rank is provided for this state.

[71] NARAL and NARAL Foundation, *Who Decides? A State-By-State Review of Abortion and Reproductive Rights*, 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2000), xxi.

[72] Stanley K. Henshaw, "Abortion Incidence and Services in the United States, 1995-1996," *Family Planning Perspectives* 30 (November/December 1998), 263-270, 287.

[73] The data for this benchmark (percentage of women living in a county without access to an obstetrician/gynecologist) are from the Alan Guttmacher Institute, Special Data Request (data run May 2000). The data file used is from the Bureau of Health Professions, *Area Resource File* (Rockville: U.S. Health Resources Service Administration, Bureau of Health Professions, 1994). While the data file used lacks hospital and clinic physicians, few counties would have full-time hospital or clinic obstetrician/gynecologists and none in office-based practices.

[74] Cynthia Costello, *Prescription for Change: Why Women Need a Medicare Drug Benefit* (Washington, D.C.: OWL, 2000).

[75] David Gross and others, *Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older: 1999 Projections* (Washington, D.C.: AARP Public Policy Institute, 1999), 1.

[76] Mary Jo Gibson and others, *How Much Are Medicare Beneficiaries Paying Out-of-Pocket for Prescription Drugs?* (Washington, D.C.: AARP Public Policy Institute, 1999), 1.

[77] ***Data Source: Medicaid Prescription Number Limits, 2000.*** National Pharmaceutical Council (NPC), *Pharmaceuticals Benefits Under State Medical Assistance Programs* (Reston: NPC, 2000), 4-48 [Online]; Available: WWW URL: http://www.npcnow.org/productlist/mppd.asp, accessed 3 October 2001; AZ Data Source: Conversation with Branch McNeil, Deputy Director, Arizona Health Care Cost Containment System (AHCCCS), 3 July 2001. OH Data Source: Conversation with Robert Reid, Pharmacy Program Coordinator, Ohio Department of Job and Family Services, 3 July 2001. TN Data Source: Rules of Tennessee Department of Finance and Administration, Bureau of TennCare, "General Rules: 1200-13-1-.03: Amount, Duration, and Scope of Assistance," September 2001 (Revised) [Online]; Available: WWW URL: http://www.state.tn.us/sos/rules/1200/1200-13/1200-13-01.pdf, accessed 3 October 2001.

[78] Claudia Schlosberg and Sareena Jerath, National Health Law Program (NHeLP), "Fact Sheet: Prescription Drug Coverage Under Medicaid," July 1999 [Online]; Available: WWW URL: http://nhelp.org/pubs/19990808MedicaidDrugs.html, accessed 21 August 2001 (citing HCFA 2082 Data, 1997, Table 3, "Medicaid Recipients by Type of Service and By State: FY 1997").

[79] 42 U.S.C. §§ 1396a(a)(1)(A)(ii), 1396d(a)(6) to 1396d(a)(16), 1396d(a)(18); 42 C.F.R. §§ 436.300 to 436.330. This indicator refers only to the limit on the number of prescriptions in a particular time period, not limits on quantities (e.g., limiting to a 30-day supply) or refills.

[80] Stephen Soumerai and others, "Effects of Limiting Medicaid Drug-Reimbursement Benefits on the Use of Psychotropic Agents and Acute Mental Health Services by Patients with Schizophrenia," *The New England Journal of Medicine* 331 (8 September 1994), 650-655 (three prescriptions per month payment limits results in increased need for acute mental health care services among low-income patients with chronic mental illnesses).

[81] ***Data Source: Medicaid Prescription Co-payments ($), 2000.*** National Pharmaceutical Council (NPC), *Pharmaceuticals Benefits Under State Medical Assistance Programs* (Reston: NPC, 2000), Table 4-51. AZ Data Source: Conversation with Branch McNeil, Deputy Director, Arizona Health Care Cost Containment System (AHCCCS), 3 July 2001. TN Data Source: "Copay Implementation Rules," 7 March 2001 [Online] Available: WWW URL: http://www.state.tn.us/tenncare/copayimp.html, accessed 6 July 2001.

[82] Stephen Soumerai and others, "Payment Restrictions for Prescription Drugs Under Medicaid," *The New England Journal of Medicine* 317 (27 August 1987), 550-556 (examining effect of one dollar co-payment policy); Stephen Soumerai and others, "A Critical Analysis of Studies of State Drug Reimbursement Policies: Research in Need of Discipline," *The Milbank Quarterly* 71 (1993), 217-251 (co-payment as low as 50 cents to one dollar per prescription can affect Medicaid enrollees' decision to fill prescription).

[83] The 2000 *Report Card* incorrectly stated that Wisconsin and Wyoming hade the *Report Card* policy; in fact, they did not.

[84] ***Data Source: Non-Medicaid Pharmaceutical Programs, 2001.*** David Gross, *State Pharmacy Assistance Programs 2001: An Array of Approaches* (Washington, D.C.: AARP Public Policy Institute, 2001); "State Pharmaceutical Assistance Programs" (Washington, D.C.: National Conference of State Legislatures, 7 September 2001) [Online]; Available: WWW URL: http://www.ncsl.org/programs/health/drugaid.htm, accessed 8 September 2001; Carla I. Plaza, *Pharmaceutical Assistance for the Elderly* (Washington, D.C.: National Conference of State Legislatures Health Policy Tracking Service, June 1, 2001).

[85] David Gross and Sharon Bee, *State Pharmacy Assistance Programs* (Washington, D.C.: AARP Public Policy Institute, 1999); Stephen Soumerai and others, "Sounding Board: Inadequate Prescription-Drug Coverage for Medicare Enrollees: A Call to Action," *The New England Journal of Medicine* 340 (4 March 1999), 722-727; National *Pharmaceutical Council, Pharmaceutical Benefits Under State Medical Assistance* (Reston: National Pharmaceutical Council, 1998), 5-3 to 5-19.

[86] The state pharmaceutical programs tend to be in one of five categories: direct benefits programs (which require states to pay for all or part of the prescription cost); insurance programs (requires enrollees to pay a premium for prescription drug insurance, often including subsidies for lower-income populations); price reduction programs (which limit the prices that can be charged to residents for their prescriptions but unlike direct-benefit and insurance programs, do not directly pay for the prescriptions); buying pools (state-sponsored programs that offer residents a chance to enroll in a purchasing pool or club, and that contract with private entities to negotiate discounts from pharmacies or drug manufacturers that can be passed on to pool members); and state income tax credit programs. David Gross, *State Pharmacy Assistance Programs 2001: An Array of Approaches"* (Washington, D.C.: AARP, July, 2001), 1-2.

[87] The programs in seven states (AZ, AR, IA, KS, TX, OR, WI) were not yet operational as of September 2001. There have also been increasing court challenges to the state pharmaceutical programs, including those in Vermont and Washington. David Gross, *State Pharmacy Assistance Programs 2001: An Array of Approaches"* (Washington, D.C.: AARP, July, 2001).

[88] ***Data Source: AIDS Drug Assistance Programs, 2001.*** Arnold Doyle, Chris Aldridge, Richard Jefferys and Jennifer Kates, *National ADAP Monitoring Project: Annual Report* (New York: National Alliance of State and Territorial AIDS Directors and AIDS Treatment Data Network, March 2001). EXPLANATION: Federal poverty guidelines for 2001 were used for this indicator.

[89] Arnold Doyle, Chris Aldridge, Richard Jefferys and Jennifer Kates, *National ADAP Monitoring Project: Annual Report* (New York: National Alliance of State and Territorial AIDS Directors and AIDS Treatment Data Network, March 2001), 10.

[90] Utah's ADAP eligibility is determined by a sliding scale, but it is categorized as being between 200 and 400 percent since there are no participants over 400 percent, and one-fifth of participants have incomes between 200 percent and 400 percent of the federal poverty guidelines. *Ibid.* Appendix IX. Advocates also note that the co-payment becomes especially burdensome for participants with incomes at 250 percent of the federal poverty guidelines. Conversation with Richard Jefferys, National ADAP Monitoring Project, May 2000.

[91] "Long-term care" includes both nursing homes and services provided in the home or in the community. Such care can include various medical services and assistance with daily living activities (e.g., dressing, bathing, and eating) for people with chronic long-term conditions that reduce their ability to function independently. AARP, *Election Issue Briefs: AARP on Long-term Care* (Washington, D.C.: AARP 2000) [Online]; Available: WWW URL: http://www.aarp.org/election2000/longterm.html, accessed 10 September 2001.

[92] National Center for Health Statistics (NCHS), *National Nursing Home Survey, 1995* [Online]; Available: WWW URL: http://www.cdc.gov/nchs/datawh/statab/pubd/ad289tb1.htm, accessed 10 September 2001; NCHS, National Home and Hospice Care Survey, 1996 [Online]; Available: WWW URL: http://www.cdc.gov/nchs/datawh/statab/ pubd/ad297tb5.htm, accessed 10 September 2001.

[93] AARP, *Election Issue Briefs: AARP on Long-term Care* (Washington, D.C.: AARP 2000) [Online]; Available: WWW URL: http://www.aarp.org/election2000/longterm.html, accessed 10 September 2001 (discussing limitations of Medicaid and private insurance coverage for long-term care). State-mandated nursing home staffing levels are also important to ensuring women's access to quality long-term care but it is still difficult to identify the most appropriate ways to evaluate state commitment to adequate staffing. One recent study, however, offers useful information to examine the issue further. See Charlene Harrington, *State Minimum Nurse Staffing Standards for Nursing Facilities* (University of California San Francisco: unpublished manuscript, 2001) (available from the author, chas@itsa.ucs.edu).

[94] ***Data Source: Paid Ombudsman Program Staff, FY 1999.*** Administration on Aging, "1999 National Ombudsmen Reporting System Data Tables, Table A-1: Selected Information by State," [Online]; Available: WWW URL: http://www.aoa.ltcombudsman/99nors/default.htm, accessed 1 June 2001.

[95] 42 U.S.C. § 3058g; Administration on Aging, "Long-Term Care Program," 28 April 1999 [Online]; Available: WWW URL: http://www.aoa.gov/factsheets/ombudsman.html, accessed 10 September 2001.

[96] Institute of Medicine, *Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act* (Washington, D.C.: National Academy Press, 1994), 175, Table 5.5d. The ratio of paid ombudsman program staff (funded by state, regional, and local governments, with some state responsibility for overseeing the regional and local programs) to the number of beds in all facilities is obtained by comparing the number of paid ombudsman program staff (not including clerical staff, see Administration on Aging, "1999 National Ombudsmen Reporting System Data Tables, Table A-8: Staff and Volunteer for FY 1999," [Online]; Available: WWW URL: http://www.aoa.ltcombudsman/99nors/default.htm, accessed 1 June 2001) to the number of beds in all facilities (licensed nursing facilities, and licensed board and care, and similar facilities). Although states may have an effective volunteer ombudsman corps, the IOM report determined that the appropriate measure involved *paid* ombudsmen. The number used in the *Report Card* is for full-time equivalents (FTEs), i.e., not all of the ombudsmen serve this role in a full-time capacity.

[97] Administration on Aging, *1999 National Ombudsman Report System Data Tables* (Washington, D.C.: Administration on Aging, 2000) [Online]; Available: WWW URL: http://www.aoa.gov/ltcombudsman/99nors/, accessed 1 June 2001.

[98] ***Data Source: Medicaid Spousal Impoverishment, 2001.*** Eric Carlson, "Appendices, Section 7.401, State-Specific Chart of Resource and Income Allowance, and Average Monthly Private Pay Rates," in *Long-term Care Advocacy*, (Los Angeles: Lexis Publishing, 2001), 7-133 to 7-135.

[99] For the "community spouse resource allowance," states must allow the community spouse to retain the greater of: (1) a minimum of $17,400 and a maximum of $87,000 in assets or (2) half the couple's joint assets up to $87,000. For the "income allowance," the community spouse can retain his or her own income, but also has the right to retain some or all of the resident's income, according to the state-established Minimum Monthly Maintenance Needs Allowance (MMMNA) that, according to federal law, must be at least $1,407 and no more than $2,103. Hawaii and Alaska are set higher because of a higher poverty level, FY 2001; Eric M. Carlson, *Long-Term Care Advocacy* (New York: Lexis Publishing, 2001), 7-49; 42 U.S.C. § 1396r-5(d); *Federal Register* 66 (2001), 10695.

[100] 42 U.S.C. § 1396r-5; Eric M. Carlson, *Long-Term Care Advocacy* (New York: Lexis Publishing, 2001), 7-24 to 7-48.

[101] ***Data Source: Medicaid Home and Community-Based Care (number per 1,000, age 18 and over) 1999.*** Martin Kitchener and others, *An Analysis of State Variation in the Growth of Medicaid Home and Community Based Services*

(University of California San Francisco: unpublished manuscript, 2001), Table 5 (available from the authors, martink@itsa.ucsf.edu), analysis of HCFA Form 372 data, U.S. Census Bureau data, and state surveys. EXPLANATION: The Home and Community-Based Services" (HCBS) and "Home and Community-Based Care" (HCBC) are often used interchangeably to refer generally to services provided in the home and the community. However, the home and community based HCB "waiver" program specifically refers to the Medicaid waiver program under § 1915(c) of the Social Security Act (42 U.S.C. Ch. 7) and is narrower than home and community-based care generally. The indicator includes both these 1915(c) "waiver" programs and "personal care" programs, but not "home health" because home health can address more acute than long-term care needs. The source does not analyze Arizona data. The source also addresses duplication across the programs using information from the Waiver Application form as well as information gathered directly from the state so that, for example, people who receive HCB services through two programs are only counted once.

[102] See also Enid Kassner and Lee Shirley, *Medicaid Financial Eligibility for Older People: State Variations in Access to Home and Community-based Waiver and Nursing Home Services* (Washington, D.C.: AARP, 2000); Lisa Alecxih and others, *The Efficacy of Using Home and Community-Based Care as an Alternative to Nursing Facility Care in Three States* (Washington D.C.: AARP, 1996) (Oregon has more than doubled the number of people who receive long-term care services in a home and/or community based setting by centralizing responsibilities in one agency, effectively coordinating with local governments, and streamlining the application process; Washington and Colorado also have innovative home and community-based programs).

[103] 42 C.F.R. §§ 440.180 to 440.181; 42 C.F.R. Pt. 441, Subpts. G and H.

[104] A "mental disorder" is "a health condition marked by an alteration in thinking, mood, or behavior (or some combination thereof) that is associated with distress and/or impaired functioning." U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999), 227. U.S. Department of Health and Human Services, "HHS Releases Additional $20 Million in Emergency Grants to States for Mental Health Services Following Attacks," *HHS News* (29 October 2001)[Online]; Available: WWW URL WWW: http://www.hhs.gov/news/press/2001pres/20011029.html, accessed 9 November 2001.

[105] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999), 408, 418.

[106] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999), 426.

[107] Georgia was mistakenly put in the limited policy category in the *2000 Report Card*, based on incorrect information from the source for the data. The comparison between the states' performance in the two *Report Cards* is based on the corrected information for the first *Report Card*. Thus the limited policy category lost a state in the 2000 *Report Card* resulting in four states despite the addition of three new states.

[108] ***Data Source: Mental Health Parity, 2001.*** National Mental Health Association. (NMHA), *What Have States Done to Pass Parity?* (Washington, D.C.: NHMA, 2001). Data for the District of Columbia were provided by Erica Malik, NMHA, August 2001.

[109] The Mental Health Parity Act of 1996 prohibits all health plans that offer mental health benefits from setting lower lifetime and annual dollar limits on mental health benefits than any similar dollar limits for medical and surgical benefits, with a few exceptions. The Act does not apply to benefits for substance abuse or chemical dependency, it does not apply to employers with fewer than 51 employees, and any group health plan whose costs increase one percent or more due to application of the law can claim an exemption from it. 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-5.

[110] Massachusetts is the only state that provides coverage of trauma counseling or other services provided to rape survivors. National Mental Health Association. (NMHA), *What Have States Done to Pass Parity?* (Washington, D.C.: NHMA, 2001). Data updated through conversations with Erica Malik, NMHA, 1 July 2001. Missouri is considered to be in the limited category because the law requires insurers to cover mental health services only after a person spends a certain amount out of pocket.

[111] Georgia was mistakenly put in the limited policy category in the *2000 Report Card* based on incorrect information from the source used for the *2000 Report Card*. Thus the limited policy category lost a state in the *2001 Report Card* resulting in four states despite the addition of three new states. States that only mandate that insurers offer treatment, but do not actually mandate the provision of coverage, are considered as having no policy.

[112] ***Data Source: Eating Disorder Parity, 2001***. National Mental Health Association. (NMHA), *What Have States Done to Pass Parity?* (Washington, D.C.: NHMA, 2001). Data for the District of Columbia were provided by Erica Malik, NMHA, August 2001.

[113] *Healthy People 2010*, 18-8.

[114] Georgia was mistakenly put in the meets policy category in the *2000 Report Card*, based on incorrect information from the source used for the 2000 *Report Card*. Thus the meets policy category lost a state in the 2001 *Report Card* resulting in 11 states despite the addition of two new states.

[115] ***Data Source: Depression Parity, 2001.*** National Mental Health Association. (NMHA), *What Have States Done to Pass Parity?* (Washington, D.C.: NHMA, 2001). Data for the District of Columbia were provided by Erica Malik, NMHA, August 2001.

[116] That disparity also appears for anxiety disorders and mood disorders. U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999), 225-226.

[117] Georgia was mistakenly put in the limited policy category in the 2000 *Report Card* based on incorrect information from the source used for the 2000 *Report Card*. Thus the meets policy category lost a state in the 2001 *Report Card* resulting in 22 states despite the addition of three new states.

[118] ***Data Source: Diabetes-related Services, 2001.*** National Conference of State Legislatures, "Mandated Benefits: Diabetes," 13 July 2001 [Online]; Available: WWW URL: www.hpts.org/HPTS97/home.nsf, accessed 2 August 2001. Data for the District of Columbia were collected for the *Report Card* by the National Conference of State Legislatures Health Policy Tracking Service, 23 July 2001. Utah data updated in conversation with Mike Mawby, American Disabilities Association, January 2001.

[119] Utah enacted a statute in 2000 requiring the Insurance Commissioner to promulgate a rule regarding diabetes coverage by July 1, 2000. The Commissioner did so (R590-200) and the rule promulgated meets policy by covering both diabetes supplies and education.

[120] American Cancer Society, *What are the Key Statistics for Cervical Cancer?* (Washington, D.C.: American Cancer Society, 2001) [Online]; Available: WWW URL: http://www.cancer.org.htm, accessed 4 October 2001; National Breast Cancer Coalition, *Fact About Breast Cancer in the United States: Year 2001* (Washington, DC.: National Breast Cancer Coalition, 2001) [Online]; Available: WWW URL: http://www.natlbcc.org.htm, accessed 4 October 2001.

[121] American Cancer Society, *What are the Key Statistics for Cervical Cancer?* (Washington, D.C.: American Cancer Society, 2001) [Online]; Available: WWW URL: http://www.cancer.org.htm, accessed 4 October 2001; National Breast Cancer Coalition, *Fact About Breast Cancer in the United States: Year 2001* (Washington, D.C.: National Breast Cancer Coalition, 2001) [Online]; Available: WWW URL: http://www.natlbcc.org.htm, accessed 4 October 2001.

[122] ***Data Source: Medicaid Breast and Cervical Cancer Treatment, 2001.*** National Conference of State Legislatures, Health Policy Tracking Service, October 2, 2001 (unpublished data, specifically collected for the *Report Card*). Conversation with Alana Wexler, National Breast Cancer Coalition, September 2001.

[123] The Breast and Cervical Treatment Act of 2000 gives states the option of providing Medicaid coverage to low-income women screened and diagnosed with breast and cervical cancer through the Centers for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program. 42 U.S.C. § 300n.

[124] Established through the Breast and Cervical Cancer Mortality Prevention Act of 1990, 42 U.S.C. § 300k.

[125] Memorandum from Timothy M. Westmoreland, Director, Health Care Financing Administration Guidance to State Health Officials on Implementing PL 106-354, January 4, 2001 [Online]; Available: WWW URL: http://www.hcfa.gov/Medicaid/sho01041.htm, accessed 17 September 2001.

[126] Memorandum from Timothy M. Westmoreland, Director, Health Care Financing Administration Guidance to State Health Officials on Implementing PL 106-354, January 4, 2001 [Online]; Available: WWW URL: http://www.hcfa.gov/Medicaid/sho01041.htm, accessed 17 September 2001.

[127] The basic option mandates full Medicaid coverage for uninsured women under 65 who are identified through the CDC's National Breast and Cervical Cancer Early Detection Program and are in need of treatment. Ten states (AK, GA, IA, MD, NE, NH, ND, RI, SD, WA) have gone beyond offering the basic option by expanding the screening program network (i.e., states can certify other providers as part of the CDC's screening network so as to cover people screened under more programs), providing presumptive eligibility, or providing coverage for others not covered by the Act (i.e., underinsured, resident aliens, etc.)

[128] ***Data Source: Breast Reconstructive Surgery, 2001.*** National Conference of State Legislatures Issue Brief, "Minimum Inpatient Mastectomy Length of Stay and Breast Reconstructive Surgery," 16 July 2001[Online]; Available: www.hpts.org/HPTS97/home.nsf, accessed 23 July 2001.

[129] 143 Cong. Rec. E159-01 (5 February 1997) (Statement of Hon. Susan Molinari on the Women's Health and Cancer Rights Act of 1997).

[130] The Women's Health and Cancer Rights Act of 1998, 29 U.S.C. § 1185b, 42 U.S.C. §§ 300gg-6, 300gg-52.

[131] ***Data Source: Mastectomy Hospital Stay, 2001.*** National Conference of State Legislatures Issue Brief, "Minimum Inpatient Mastectomy Length of Stay and Breast Reconstructive Surgery," 16 July 2001[Online]; Available: www.hpts.org/HPTS97/home.nsf, accessed 23 July 2001.

[132] The Women's Health and Cancer Rights Act of 1998, 29 U.S.C. § 1185b, 42 U.S.C. §§ 300gg-6, 300gg-52.

[133] *Healthy People 2010*, 9-15, 9-16.

[134] Rachel Benson Gold, "The Need for and Cost of Mandating Private Insurance Coverage of Contraception," *The Guttmacher Report on Public Policy* 1 (August 1998), 5-7.

[135] ***Data Source: Contraceptive Coverage, 2001.*** Alan Guttmacher Institute (AGI), State Policies in Brief, Insurance Coverage of Contraceptives (Washington, D.C.: AGI, 2001); NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights,* 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2001). EXPLANATION: Prescription contraceptives include: oral contraceptives, including emergency contraception (the "morning after pill"); injections like Depo Provera and Lunelle; implants like Norplant; IUDs; and barrier methods such as diaphragms and cervical caps. A federal bill, the Equity in Prescription Insurance and Contraceptive Coverage Act of 2001 (S. 104, 107th Cong.) is pending and would require any insurer that covers prescription drugs and devices to also cover FDA-approved prescription contraceptive drugs and devices. In addition, in 1998, a federal law was enacted that required all health insurance plans made available to federal employees to include coverage of prescription contraceptives if other prescription drugs are covered. Appropriations, 2000 – Treasury, Postal Service, Executive Office of the President, and General Government, Pub. L. No. 106-58, § 635, 113 Stat. 430.

[136] The Washington state insurance commissioner recently signed a rule that would require health plans to include contraceptives in their prescription drug coverage based on the state's sex discrimination law. The rule becomes effective January 1, 2002. Washington Administrative Code § 284-43-822. *See also* Carol M. Ostrom, "Kreidler Signs New Rule Forcing Insurers to Cover Birth Control," *Seattle Times*, 6 September 2001, B4.

[137] The data source for the 2000 *Report Card* mistakenly omitted a 1996 Oklahoma regulation requiring coverage for preventive health services that has been interpreted to require HMOs to provide coverage for some type of contraceptive drug or device. The same regulation is still in effect and Oklahoma is currently described by this *Report Card* as having limited coverage.

[138] The 2000 *Report Card* mistakenly omitted this statute, which has been in effect since 1997 and is currently described as weak coverage for contraception.

[139] ***Data Source: Family Planning Medicaid Waiver, 2001.*** Alan Guttmacher Institute (AGI), *State Policies in Brief, Medicaid Family Planning Waivers* (Washington, D.C.: AGI, July 2001).

[140] *Healthy People 2010*, 9-6, 9-7.

[141] Waivers expand coverage for women in one of the following categories: (1) women after postpartum period; (2) women losing Medicaid for any reason; and (3) women who meet specific income requirements. Twelve states (AL (Mobile County, only), AZ, CO, FL, GA, MD, MO, NY, RI, SC, VA, WA) have applied for or have received waivers to extend coverage to women after the postpartum period. The waivers for four states (CO, GA, VA, WA) were pending approval as of July 1, 2001. One state (DE) extends coverage to women losing Medicaid for any reason. Thirteen states have applied for or received waivers to extend coverage to women who meet the income requirements listed as percentage of federal poverty guidelines. (AL: 133 percent, AR: 133 percent, CA: 200 percent, CO: 150 percent, KY: 185 percent, MS: 185 percent, NM: 185 percent, NY: 200 percent, NC: 185 percent, OR: 185 percent, SC: 185 percent, WA: 200 percent, WI: 185 percent). The waivers for six states (CO, KY, MS, NY, NC, WI) were pending approval as of July 1, 2001.

[142] Rachel Benson Gold, "California Program Shows Benefits of Expanding Family Planning," *The Guttmacher Report on Public Policy* 3 (October 2000), 1, 2, 11 (reporting that program increased use of more effective contraceptive methods in 40 percent of its 670,000 participants, thus preventing 108,000 unintended pregnancies in California alone).

[143] Two states (HI, OK) have submitted "pre-application" concept papers, but they have yet to submit actual applications. Alan Guttmacher Institute (AGI), *State Policies in Brief, Medicaid Family Planning Waivers* (Washington, D.C.: AGI, July 2001). Because this is only a preliminary step in women actually getting family planning services under Medicaid, the *Report Card* does not count these as having a policy.

[144] Adam Sonfield, "Drive for Insurance Coverage of Infertility Raises Questions of Equity, Cost," *The Guttmacher Report on Public Policy* 2 (October 1999), 4-5. See also Amara Bachu and Martin O'Connell, *Fertility of American Women: June 2000* (Washington, D.C.: U.S. Census Bureau, 2001), Current Population Reports No. P20-543 [Online]; Available: WWW URL: http://www.census.gov/prod/2001pubs/p20-543.pdf, accessed 19 October 2001.

[145] Adam Sonfield, "Drive for Insurance Coverage of Infertility Raises Questions of Equity, Cost," *The Guttmacher Report on Public Policy* 2 (October 1999), 4-5.

[146] 142 Cong. Rec. S9903-05 (5 September 1996) (Statement of Senator Bill Bradley on the Newborns' and Mothers' Health Protection Act of 1996).

[147] American Medical Association, *Impact of 24-Hour Postpartum Stay on Infant and Maternal Health, June 1995* [Online]; Available: WWW URL: http://www.ama-assn.org/ama/pub/article/2036-2541.html, accessed 23 August 2001 (regarding length of hospital stay being determined by physician).

[148] ***Data Source: Maternity Stays, 2001.*** National Conference of State Legislatures, "Women's Health: Minimum Inpatient Maternity Stays," 16 July 2001 [Online]; Available: WWW URL: www.hpts.org/HPTS97/home.nsf, accessed 24 July 2001. EXPLANATION: The issue brief reports that since 1995, 46 states have mandated coverage for minimum hospital stays (according to the 48/96 standard).

[149] Florida law states that an insurer cannot limit the amount of coverage for the length of the maternity stay. Five states (IN, ME, FL, VT, VA, WA) expressly follow guidelines set by the American College of Obstetricians and Gynecologists (ACOG), which state that the length of the maternal stay should be determined by the physician. American Academy of Pediatricians and American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care*, 4th ed. (Washington, D.C.: AAPA and ACOG, 1997). A 1996 federal law, the Newborns' and Mothers' Health Protection Act of 1996, provides some protections for new mothers by requiring insurance companies and HMOs to cover 48-hour stays for vaginal deliveries, and 96-hour stays for cesareans. 29 U.S.C. § 1185, 42 U.S.C. §§ 300gg-4, 300gg-51. Delaware has a resolution that requests that inpatient care decisions be made by the physician in consultation with the mother.

[150] ***Data Source: Infertility Treatment Coverage, 2001.*** RESOLVE: the National Infertility Association, *Health Insurance Coverage of Infertility Treatment*, 1999 [Online]; Available: WWW URL: http://www.resolve.org/advstlaws.htm, accessed 10 August 2001. NJ: RESOLVE Advocacy Alert 31 August 2001 [Online]; Available: WWW URL: http://www.resolve.org/advocacy.htm, accessed 5 October 2001. Kate Doyle, "Coverage for Infertility" (Boston: RESOLVE: The National Infertility Association, 2001). National Conference of State Legislatures, "Women's Health: Coverage for Infertility Treatments," 1 June 2001 [Online]; Available: WWW URL: www.hpts.org/HPTS97/home.nsf, accessed 24 July 2001. Data updated through conversation with Kate Doyle, RESOLVE, October 2001. The 2000 *Report Card* incorrectly lists New York as having the policy; in fact, it had a weak policy.

[151] Some state laws mandating insurance coverage of infertility treatment are written broadly and others single out specific treatments. The *Report Card* does not differentiate among states according to the specific procedures for which they require coverage and considers a state to mandate coverage of infertility treatment in a non-limited way if the state's mandate applies to all insurance companies.

[152] Roe v. Wade, 410 U.S. 113 (1973).

[153] NARAL and NARAL Foundation, *Who Decides? A State-By-State Review of Abortion and Reproductive Rights*, 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2001), v.

[154] ***Data Source: Clinic Access, 2001.*** Alan Guttmacher Institute (AGI), *The Status of Major Abortion-Related Policies in the States* (Washington, D.C.: AGI, May 2001); NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights,* 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2001), 272-273. EXPLANATION: Similar to FACE, Washington's law protects both those seeking and providing reproductive health services from physical attacks and the threats thereof, requires unimpeded entrance to and exit from health care facilities, and protects facilities from property damage. In addition, the Washington law has criminal penalties, allows victims to go into court to stop any actions forbidden by the law, and allows victims to sue the violators for monetary damages and attorneys' fees. Revised Code of Washington, §§ 9A.50.005 to 9A.50.902.

[155] For current statistics on clinic violence, see National Abortion Federation, "Violence Statistics 1977- Present" (Washington, D.C., National Abortion Federation, 2001) [Online]; Available: WWW URL: http://209.9.126.227/NAFweb/Violence/stats.pdf, accessed 2 August 2001. See also "Abortion Providers Call for Greater Response from Law Enforcement to Anthrax Threats Sent to Clinics," *Kaiser Daily Reproductive Health Report* (22 October 2001)[Online]; Available: WWW URL: http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=7581&dr_cate=2, accessed 9 November 2001.

[156] 18 U.S.C. § 248.

[157] National Abortion Federation, "Freedom of Access to Clinic Entrances Act," 2000 [Online]; Available: WWW URL: http://www.prochoice.org/default7.htm, accessed 2 August 2001.

[158] ***Data Source: Abortion Procedures Ban, 2000.*** NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2001), 272-273.

[159] NARAL and NARAL Foundation, *Who Decides? A State-By-State Review of Abortion and Reproductive Rights,* 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2001), xvi; American Medical Association, Policy H-5.982, *AMA Policy: Late-Term Pregnancy Termination Techniques,* 1999 [Online]; Available: WWW URL: http://www.ama-assn.org/apps/pf_online/pf_online, accessed 2 August 2001 (noting that "partial birth" is not a medical term and finding that the procedure used is best left to a physician in consultation with his or her patient).

[160] Stenberg v. Carhart, 530 U.S. 914 (2000).

[161] ***Data Source: Parental Consent/Notification, 2000.*** NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights,* 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2001), 266-267. EXPLANATION: The *Report Card* does not count states with laws that have been enjoined or not enforced (as described by NARAL) as having a parental involvement law.

[162] Some states also allow other adult relatives to give consent or receive notice. NARAL and NARAL Foundation, *Who Decides? A State-By-State Review of Abortion and Reproductive Rights*, 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2001), 266-267.

[163] Stanley K. Henshaw, "The Impact of Requirements for Parental Consent on Minors' Abortions in Mississippi," *Family Planning Perspectives* 27 (May/June 1995), 120-122.

[164] ***Data Source: Waiting Periods, 2000.*** NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2001), 265. EXPLANATION: The *Report Card* does not count states with laws that have been enjoined or not enforced (as described by NARAL) as having a waiting period.

[165] David Grimes and others, "Morbidity and Mortality from Second-trimester Abortions," *Journal of Reproductive Medicine* 30 (1985), 505-514; Rachel Benson Gold, *Abortion and Women's Health: A Turning Point for America?* (New York and Washington, D.C.: Alan Guttmacher Institute, 1990).

[166] Ted Joyce and Robert Kaestner, "The Impact of Mississippi's Mandatory Delay Law on the Timing of Abortion," *Family Planning Perspectives* 32 (January/February 2000), 4-13.

[167] Stanley K. Henshaw, "Abortion Incidence and Services in the United States, 1995-1996," *Family Planning Perspectives* 30 (November/December 1998), 263-270, 287.

[168] Virginia added its waiting period after the release of the source for this indicator. Va. H.B 2570 (An Act to amend and reenact §§ 16.1-77 and 18.2-76 of the Code of Virginia, relating to abortion, informed written consent as a prerequisite for a lawful abortion; penalty) (signed March 26, 2001).

[169] ***Data Source: Public Funding for All Medically Necessary Abortions, 2000.*** NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights,* 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2001). EXPLANATION: The *Report Card* includes states that have been required by federal or state courts to provide funding.

[170] 146 Cong. Rec. H12100, H12119, Conference Report on H.H. 4577, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2001 (H.R. 4577, Tit.V, §§ 508, 509) (December 15, 2000).

[171] Clinic for Women, Inc. v. Humphreys, No. 49D12-9908-MI-1137 (Ind. Super. Ct. Oct. 18, 2000), appeal filed, No. 49-5OO-0011-CV-714 (Ind. Nov. 21, 2000) (Indiana) (on file with the National Women's Law Center); Low-Income Women of Texas v. Bost, 38 S.W.3d 689 (Tex. Ct. App. 2000), petition for review filed, No. 01-0061 (Tex. Jan 22, 2001) (Texas).

[172] In a ruling issued after the data source for this *Report Card* was published, the Arizona Court of Appeals upheld the state's ban on public funding for medically necessary abortions. Simat Corp. v. Arizona Health Care Cost Containment System Admin., No. 1 CA-CV 00-0334 (Ariz. Ct. App., Aug. 7, 2001), rev'g Simat Corp. v. Arizona Health Care Cost Containment System Admin., No. CV 99-14614 (Ariz. Super. Ct. May 23, 2000) (minute entry), (Ariz. Super. Ct. June 26, 2000) (order).

[173] ***Data Source: Domestic Violence Health Care Provider Protocols, Training and Screening Mandates, 2001***. Family Violence Prevention Fund, *State-by-State Report Card on Health Care Laws and Domestic Violence* (San Francisco: Family Violence Prevention Fund, 2001) [Online]; Available: WWW URL: http://endabuse.org/statereport/list.php3, accessed 3 October 2001.

[174] Lori Heise and others, "Ending Violence Against Women," *Population Reports* Series L (1999), 26-36 (citing other sources).

[175] Lori Heise and others, "Ending Violence Against Women," *Population Reports* Series L (1999), 26-36 (citing other sources).

[176] The source for the 2000 *Report Card* incorrectly omitted West Virginia's laws requiring training and protocols, even though these laws went into effect in 1998. W. Va. Code §§ 48-2C-4b, 48-2C-10a, 48-2C-13a. The correct number of states in this category in the 2000 *Report Card* should have been four, and not three.

[177] ***Data Source: Domestic Violence Anti-Discrimination in Insurance, 2001.*** Terry Fromson and Nancy Durburow, *Insurance Discrimination Against Victims of Domestic Violence* (Harrisburg: Pennsylvania Coalition Against Domestic Violence Publications, 1998 (joint report by Pennsylvania Coalition Against Domestic Violence and the Women's Law Project); updated with unpublished data from Terry Fromson, Women's Law Project, on file with the National Women's Law Center (June 2001).

[178] Studies in 1994 and 1995 indicated that approximately one out of four insurance companies engaged in these practices, and one study (Pennsylvania) reported that 74 percent of life insurers and 65 percent of health insurers used domestic violence as a criterion in review of new applications. *Ibid.* at 2.

[179] *Ibid.* at 3-4.

[180] The Health Insurance Portability and Accountability Act (HIPAA), 26 U.S.C. § 9801; 29 U.S.C. § 1181, 42 U.S.C. § 300gg.

[181] ***Data Source: Sexual Assault Health Care Provider, Police, and Prosecutor Training, 2000.*** Neal Miller, *Review of State Sexual Assault Laws, 1998 Legislative Codes* (Alexandria: Institute for Law and Justice, 1999) [Online]; Available: WWW URL: http://www.ilj.org/sa/sexaltpr.htm, accessed 1 August 2001. Neal Miller, *1999 Domestic Violence, Stalking, and Sexual Assault Legislation: State by State Analysis of 1999 Legislation* (Alexandria: Institute for Law and Justice, 2000) [Online]; Available: WWW URL: http://www.ilj.org/dv/99StateLawUpdate.htm, accessed 1 August 2001. Neal Miller, *1999 Violence Against Women Legislation* (Alexandria: Institute for Law and Justice, 2000) [Online; Available WWW URL: http://www.ilj.org/dv/99SessionLaw.htm, accessed 1 August 2001. Neal Miller, *A Review of State Domestic Violence Related Legislation: A Law Enforcement and Prosecution Perspective* (Alexandria: Institute for Law and Justice, 2000) [Online]; Available: WWW URL: http://www.ilj.org/dv/vawa1.html, accessed 1 August 2001; Neal Miller, *2000 Legislative Session: Violence Against Women Legislation* (Alexandria: Institute for Law and Justice, 1999) [Online]; Available: WWW URL: http://www.ilj.org/dv/2000SessionLaw.pdf, accessed 1 August 2001.

[182] 42 U.S.C. §§ 1395l, 1395m, 1395x, 1395y (mammograms and Pap smears – Medicaid); 42 C.F.R. §§ 410.34, 411.15(k)(6) (mammograms – Medicare); 42 C.F.R. §§ 410.56, 411.15(k)(8) (Pap smears – Medicare).

[183] ***Data Source: Pap Smears (%), 2000 (state race/ethnicity and age data 1997-1999) (national race/ethnicity data 1992-1994).*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *2000 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000), Table 38.1, 93 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. California: data from the state of California are not included in the *2000 BRFSS Summary Prevalence Report* due to differences in question wording; data for CA were obtained online from the Behavioral Risk Factor Surveillance System, "Prevalence Data: California – 2000 Risk Factors and Calculated Variables" [Online]; Available: WWW URL: http://apps.nccd.cdc.gov/brfss/display.asp?cat=RF&yr=2000&qkey=4405&state=CA, accessed 22 August 2001. Data for race/ethnicity and age at the state level are three-year averages from 1997 to 1999 and are age adjusted to the 2000 standard age population. National Center for Health Statistics, *State*

Health Statistics by Sex and Race/Ethnicity: Health Behavior and Risk Factor Tables [Online]; Available: WWW URL: http://www.cdc.gov/nchs/statestatsbysexrace.htm, accessed 20 July 2001. Data for race/ethnicity and age at the national level are from: Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention, " *Journal of American Medical Women's Association* 53 (Spring 1998), 96-107. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population with a uterine cervix who reported that they have had a pap test within the past one to three years. To be consistent with the Healthy People 2000 goal, the data from the surveys were converted from the negative to the positive: "percentage of women who report that they did not have a Pap test within the past three years" to "percentage of women who report that they did have a Pap test within the past three years." *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico (except CA).

184 Jeanne S. Mandelblatt and others, "Breast and Cervix Cancer Screening among Multiethnic Women: Role of Age, Health and Source of Care," *Preventive Medicine* 28 (1999), 418-425; Centers for Disease Control and Prevention, "Trends in Self-Reported Use of Mammograms (1989-1997) and Papanicolaou Tests (1991-1997) – Behavioral Risk Factor Surveillance System," *Morbidity and Mortality Weekly Report* 48 (8 October 1999), CDC *Surveillance Summaries* No. SS-6.

185 *Healthy People 2000*, Objective 16.2.

186 ***Data Source: Pap Smears, 2001.*** National Conference of State Legislatures, "Breast and Cervical Cancer Screening," 16 July 2001 [Online]; Available: WWW URL: www.hpts.org/HPTS97/home.nsf, accessed 23 July 2001.

187 Centers for Disease Control and Prevention, *The National Breast and Cervical Cancer Early Detection Program: At-A-Glance 1999* (Washington, D.C.: Centers for Disease Control and Prevention, 1999), 2 (describing the program enacted under the Breast and Cervical Cancer Mortality Prevention Act of 1990, 42 U.S.C. § 300k).

188 Although the Maryland Insurance Administration requires all HMOs to cover preventive services, including cervical cancer screenings, because Maryland does not have a statute requiring coverage for cervical cancer screenings the *Report Card* categorizes the state as "no policy." National Conference of State Legislatures, "Breast and Cervical Cancer Screening," 16 July 2001 [Online]; Available: WWW URL www.hpts.org/HPTS97/home.nsf, accessed 23 July 2001.

189 ***Data Source, Chlamydia Screening, 2001.*** National Conference of State Legislatures, Health Policy Tracking Service, July 2001 (unpublished data, specifically collected for the *Report Card*).

190 Centers for Disease Control and Prevention, *Some Facts About Chlamydia* (Atlanta: Centers for Disease Control and Prevention, 2000) [Online]; Available: WWW URL: http://www.cdc.gov/nchstp/dstd/chlamydia_facts.htm, accessed 20 July 2001.

191 U.S. Preventive Services Task Force, *Screening for Chlamydial Infection* (Rockville: U.S. Preventive Services Task Force, 2001) [Online]; Available: WWW URL: http://www.ahcpr.gov/clinic/prev/chlamwh.htm, accessed 20 July 2001; Gale Burstein and others, "Predictors of Repeat Chlamydia Trachomatis Infections Diagnosed by DNA Amplification Testing Among Inner City Females," *Sexually Transmitted Infections* 77 (2001), 26.

192 Gale Burstein and Anne Rompalo, "Chlamydia," in *Women & Health*, eds. Marlene B. Goldman and Maureen C. Hatch (San Diego: Academic Press, 2000), 273, 275; Centers for Disease Control and Prevention, "1998 Guidelines for Treatment of Sexually Transmitted Diseases," *Morbidity and Mortality Weekly Report* 47 (23 January 1998).

193 In the 2000 *Report Card*, Tennessee was mistakenly credited as requiring coverage; it actually only requires that insurers offer the benefit. The fact that Tennessee merely offered coverage was not noted in the source for the 2000 *Report Card.*

194 ***Data Source: Mammograms (%), 2000 (state race/ethnicity and age data 1997-1999) (national race/ethnicity data 1992-1994).*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *2000 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000) Table 30.1, 77 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. *California*: data from the state of California are not included in the *2000 BRFSS Summary Prevalence Report* due to differences in question wording; data for CA were obtained online from the Behavioral Risk Factor Surveillance System, "Prevalence Data: California – 2000 Risk Factors and Calculated Variables," [Online]; Available: WWW URL: http://apps.nccd.cdc.gov/brfss/display.asp?cat=RF&yr=2000&qkey=4404&state=CA, accessed 22 August 2001. Data for race/ethnicity and age at the *state* level are for women age 40 and over, are three-year averages from 1997 to 1999 and are age adjusted to the 2000 standard age population. National Center for Health Statistics, *State Health Statistics by Sex and Race/Ethnicity: Health Behavior and Risk Factor Tables* [Online]; Available: WWW URL: http://www.cdc.gov/nchs/statestatsbysexrace.htm, accessed 20 July 2001. Data for race/ethnicity and age at the *national* level are from: Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention, " *Journal of American Medical Women's Association* 53 (Spring 1998), 96-107. EXPLANATION: This measure includes women age 50 and over in the non-institutionalized civilian population who reported that they did not have a mammogram within the past two years. To be consistent with the Healthy People 2000 goal, the data from the surveys were converted from the negative to the positive: "percentage of women who report that they did not have a mammogram within the past two years" to "percentage of women who report that they did have a mammogram within the past two years." *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico (except CA).

195 Jeanne S. Mandelblatt and others, "Breast and Cervix Cancer Screening among Multiethnic Women: Role of Age, Health and Source of Care," *Preventive Medicine* 28 (1999), 418-425; Centers for Disease Control and Prevention, "Trends in Self-Reported Use of Mammograms (1989-1997) and Papanicolaou Tests (1991-1997) – Behavioral Risk Factor Surveillance System," *Morbidity and Mortality Weekly Report* 48 (8 October 1999), No. SS-6.

196 *Healthy People 2000*, Objective 21.2.

197 *Healthy People 2010*, Objective 3-13.

198 ***Data Source: Mammograms, 2001.*** National Conference of State Legislatures, "Breast and Cervical Cancer Screenings," 16 July 2001 [Online]; Available: www.hpts.org/HPTS97/home.nsf, accessed 24 July 2001.

199 Centers for Disease Control and Prevention, *The National Breast and Cervical Cancer Early Detection Program: At-A-Glance 1999* (Washington, D.C.: Centers for Disease Control and Prevention, 1999), 2 (describing the program enacted under the Breast and Cervical Cancer Mortality Prevention Act of 1990, 42 U.S.C. § 300k).

200 The *Report Card* uses annual screenings for women age 40 and over as its standard to determine whether states meet the policy because it is the age at which the American Cancer Society recommends women begin annual mammograms. American Cancer Society, *"FastFacts"* [Online]; Available: WWW URL: http://www.cancer.org/NBCAM_fastfacts.html, accessed 24 August 2001. Although the objective for *Healthy People 2000* was set at

requiring annual screenings for all women over 50, *Healthy People 2010* changed that objective to require screening for all women over 40. Healthy People 2010, Objective 3-13. Two states (TX, WY) and the District of Columbia offer annual mammograms to an even broader group of women, because they do not require an age limit for the annual mammography insurance mandate. National Conference of State Legislatures, "Breast and Cervical Cancer Screenings," 16 July 2001 [Online]; Available: WWW URL: www.hpts.org/HPTS97/home.nsf, accessed 24 July 2001.

[201] ***Data Source: Osteoporosis Screening, 2001.*** National Conference of State Legislatures, "Osteoporosis Screening," 16 July 2001 [Online]; Available: WWW URL www.hpts.org/HPTS97/home.nsf, accessed July 2001. Data for this indicator were analyzed by Susan Davidson, Consultant to the National Osteoporosis Foundation, July 2001.

[202] National Osteoporosis Foundation, Legislative Issue Brief, "Bone Mass Measurement– Insurance Coverage," January 1999; R.D. Wasnich and others, "Prediction of Postmenopausal Fracture Risk with Use of Bone Mineral Measurements," *American Journal of Obstetrics and Gynecology* 153 (1985), 745-751.

[203] Medicare covers bone density testing (using all FDA-approved technologies) for five categories of high-risk individuals: estrogen-deficient women at clinical risk of osteoporosis and who are considering treatment; individuals with vertebral abnormalities; individuals receiving long-term glucocorticoid (steroid) therapy; individuals with primary hyperparathyroidism; and individuals being monitored to assess the response to or efficacy of approved osteoporosis drug therapies. 42 U.S.C. § 1395x.

[204] The language of Kansas' and Missouri's laws are broader than the others in that they not only cover testing for people in the five high-risk categories but also cover people who are at risk for osteoporosis due to secondary causes like medication, certain diseases, or other medical conditions.

[205] ***Data Source: Colorectal Cancer Screening (%), 1999 (state race/ethnicity and age 1997, 1999) (national race/ethnicity data 1992-1994).*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *1999 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1997), Table 21.2, 62 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. Data for race/ethnicity and age at the *state* level are two-year averages from 1997 and 1999, except for two states (IL, IA, which include 1998 data), and are age adjusted to the 2000 standard age population. National Center for Health Statistics, *State Health Statistics by Sex and Race/Ethnicity: Health Behavior and Risk Factor Tables* [Online]; Available: WWW URL: http://www.cdc.gov/nchs/statestatsbysexrace.htm, accessed 20 July 2001. Data for race/ethnicity at the *national* level are from: Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention," *Journal of American Medical Women's Association* 53 (Spring 1998), 96-107. EXPLANATION: This measure includes women age 50 and over in the non-institutionalized civilian population who reported ever having had a sigmoidoscopy. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico. To be consistent with the Healthy People 2000 goal, the data from the survey were converted from the negative to the positive: "percentage of women age 50 and over who never had a sigmoidoscopy" to "percentage of women who have ever had a sigmoidoscopy."

[206] National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data By State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM].

[207] *Healthy People 2010*, 3-15.

[208] U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services*, 2nd ed. (Baltimore: Williams & Wilkins, 1996), 89.

[209] A sigmoidoscopy is an examination during which a hollow, lighted tube is used to visually inspect the wall of the rectum and part of the colon.

[210] *Healthy People 2000*, Objective 16.13.

[211] ***Data Source: Colorectal Cancer Screening, 2001.*** National Conference of State Legislatures Health Policy Tracking Service, 16 July 2001 (unpublished data, specifically collected for the *Report* Card).

[212] *Healthy People 2010*, 3-15, 3-16.

[213] North Carolina, Oklahoma and Texas passed legislation requiring colorectal cancer screening but the laws are ineffective until January 2002.

[214] ***Data Source: No Leisure-Time Physical Activity, (%), 2000 (state race/ethnicity and age 1996, 1998).*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *2000 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000), Table 10.2, 29 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. Data for race/ethnicity and age at the state level are two-year averages from 1996 and 1998 (except for AZ, IL, IA, KY, NJ, NY, OK, SC, TN, VA, WY, which include 1997 data) and are age adjusted to the 2000 standard age population. National Center for Health Statistics, *State Health Statistics by Sex and Race/Ethnicity: Health Behavior and Risk factor Tables* [Online]; Available: WWW URL: http://www.cdc.gov/nchs/statestatsbysexrace.htm, accessed 20 July 20, 2001. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who reported that they did not have any leisure time physical activity during the past month. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico.

[215] *Healthy People 2000*, Objective 1.5.

[216] ***Data Source: Exercise (years), 1997.*** National Association for Sport and Physical Education (NASPE), *Shape of the Nation Report: A Survey of Physical Education Requirements* (Washington, D.C.: NASPE, 1997). After the research for the 2001 *Report Card* was completed, NASPE released its updated report, *Shape of the Nation Report: A Survey of Physical Education Requirements* (Washington, D.C.: NASPE, 2001). For more information, see NASPE's website: http://www.aahperd.org/naspe/naspe_main.html.

[217] Only 52 percent of high school girls and 74 percent of high school boys met the standard for "regular vigorous physical activity" in 1995, which is defined as "exercise or sports participation that makes one sweat or breathe hard" for at least 20 minutes, three or more days per week. U.S. Department of Health and Human Services, *Physical Activity and Health: A Report of the Surgeon General* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1996), 177-192.

[218] Centers for Disease Control and Prevention, *Guidelines for School and Community Health Programs to Promote Lifelong Physical Activity Among Young People*, 6-7, reprinted in *Morbidity and Mortality Weekly Report* 46 (7 March 1997), 11-12.

[219] Secretary of Health and Human Services, *Promoting Better Health for Young People through Physical Activity and Sports*, Fall 2000 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/dash/presphysactrpt, accessed 25 July 2001.

[220] The indicator focuses on the number of years, also counted as units, of physical education required for graduation in ninth through twelfth grades; these data allow for state-by-state comparison. This measure does not take into account states where school graduation requirements are decided by the local districts, nor does the measure differentiate among states that count health as P.E. or that allow for substitutions.

[221] The Centers for Disease Control and Prevention have recommended daily P.E. for students in kindergarten through twelfth grade, a reduction in the practice of granting exemptions for P.E. classes, and an increase in the amount of time that students are active in P.E. classes. Centers for Disease Control and Prevention, "Guidelines for School and Community Health Programs to Promote Lifelong Physical Activity Among Young People," 6-7, reprinted in *Morbidity and Mortality Weekly Report* 46 (7 March 1997), 11-12.

[222] ***Data Source: Overweight (%), 1999 (national race/ethnicity data 1992-1994).*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *1999 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1997), Table 23.2, 67 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. Data for race/ethnicity at the *national* level are from Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention, " *Journal of American Medical Women's Association* 53 (Spring 1998), 96-107. EXPLANATION: This measure includes women age 18 and over who have a body mass index (BMI) of 27.3 or greater. Body mass index is a measure that adjusts body weight for height. It is calculated as weight in kilograms divided by height in meters squared. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico.

[223] *Healthy People 2000*, Objective 1.2.

[224] Katherine M. Flegal, "Obesity," in *Women & Health*, eds. Marlene B. Goldman and Maureen C. Hatch (San Diego: Academic Press, 2000), 830.

[225] ***Data Source: Eating Five Fruits and Vegetables a Day (%), 2000 (national race/ethnicity data 1992-1994).*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *2000 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000), Table 13.2, 38 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. Data for race/ethnicity at the national level are from Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention, " *Journal of American Medical Women's Association* 53 (Spring 1998), 96-107. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who report that they eat five or more servings of fruits and vegetables each day. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico. To be consistent with the Healthy People 2000 goal, the data from the BRFSS are converted from the negative to the positive: "percentage of women who report that they did *not* eat five or more servings of fruit and vegetables each day" to "percentage of women who report that they *did* eat five or more servings of fruit and vegetables each day."

[226] Shanthy A. Bowman and others, *The Healthy Eating Index 1994-99*, USDA Report CNPP-5 (Washington, D.C.: U.S. Department of Agriculture, Center for Nutrition Policy and Promotion), 3.

[227] Ashima K. Kant and others, "A Prospective Study of Diet Quality and Mortality in Women," *Journal of the American Medical Association* 283 (26 April 2000), 2109.

[228] *Healthy People 2000*, Objective 2.6.

[229] The source for the 2000 *Report Card* mistakenly reported that Alaska had a nutrition education program; in fact it does not.

[230] ***Data Source: Food Stamps Outreach, FY 2001.*** Conversation with Ellen Vollinger, Legal Director, Food Research and Action Center (FRAC), August 2, 2001.

[231] Generally, people are eligible for Food Stamps if they work for low wages, are unemployed or work part-time, receive welfare or other public assistance payments, are elderly or disabled and live on a small income, or are homeless. U.S. Department of Agriculture, Food and Nutrition Service, *Facts About the Food Stamp Program*, 2001 [Online]; Available: WWW URL: http://www.fns.usda.gov/fsp/menu/apps/facts.htm, accessed 3 August 2001.

[232] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), 42 U.S.C. Ch. 7, Subch. IV, Pt. A; Food Research and Action Center, *FRAC Special Analysis, A Guide to Food Stamp Outreach* (Washington, D.C.: FRAC, February 2000), 1-2.

[233] ***Data Source: Nutrition Education, 2001.*** U.S. Department of Agriculture (USDA), Food and Nutrition Service, Food Stamp Program, "Food Stamp Nutrition Education State Financial Expenditures," 1999. Data were updated in conversation with Alice Lockett, U.S. Department of Agriculture, July 2001.

[234] The source for the 2000 *Report Card* mistakenly reported that Alaska had a nutrition education program; in fact it does not. The correct number of states with the program for the 2000 *Report Card* was 47, and the correct number of states without the program in the 2000 *Report Card* are three and the District of Columbia.

[235] ***Data Source: Smoking (%), 2000 (state race/ethnicity and age 1997-1999) (national race/ethnicity data 1992-1994)***. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *2000 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000), Table 9.2, 26 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. Data for race/ethnicity and age at the *state* level are three-year averages from 1997 to 1999 and are age adjusted to the 2000 standard age population. National Center for Health Statistics. *State Health Statistics by Sex and Race/Ethnicity: Health Behavior and Risk Factor Tables.* [Online]; Available: WWW URL: http://www.cdc.gov/nchs/statestatsbysexrace.htm, accessed 20 July 2001. Data for race/ethnicity at the *national* level are from: Robert A. Hahn and other, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention, " *Journal of American Medical Women's Association* 53 (Spring 1998), 96-107. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who report ever smoking 100 cigarettes in their lifetime and reported smoking every day or some days. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico.

[236] *Women and Smoking: A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, 2001), 7 [Online]; Available: WWW URL: www.cdc.gov/tobacco/sgr_forwomen.htm, accessed 11 October 2001 (hereafter *"Women and Smoking"*).

[237] *Women and Smoking*, 7.

[238] *Women and Smoking*, 209.

[239] See also *Women and Smoking*, 7 (in 1998, approximately 22 percent of women smoked; in 2000, 29.7 percent of high school senior girls did).

[240] *Women and Smoking: Executive Summary of the Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, 2001), 1 [Online]; Available: WWW URL: http://www.surgeongeneral.gov/library, accessed 11 October 2001.

[241] *Women and Smoking*, 34.

[242] *Women and Smoking.*

[243] *Healthy People 2000*, Objective 3.4.

[244] *Women and Smoking.*

[245] ***Data Source: Medicaid Smoking Cessation Coverage, 1998.*** Helen Halpin and others, *Medicaid Coverage for Tobacco Dependence Treatments* (Princeton: Robert Wood Johnson Foundation, 7 December 1999). After the research for the 2001 *Report Card* was completed, a study was published on state Medicaid Coverage for Tobacco-Dependence Treatment. "State Medicaid Coverage for Tobacco-Related Dependence Treatment—United States, 1998 and 2000," *Morbidity and Mortality Weekly Report* 50 (9 November 2001), 979-982.

[246] If a state covers any one of the possible treatments under a category, the *Report Card* considers the state to cover that category, as one form of treatment within a category is not necessarily better than another (e.g., patch versus gum or individual versus group counseling). Virginia did not participate in the data collection survey, so it is not included in this indicator.

[247] Centers for Disease Control and Prevention, Office on Smoking and Health, *Best Practices for Comprehensive Tobacco Control Programs* (Atlanta: Centers for Disease Control and Prevention, August 1999), 24.

[248] Although there are some states with private insurance laws that provide coverage for smoking cessation treatment, there are not any states with strong enough policies to meet the *Report Card* policy requirement. "Smoking Cessation Coverage Requirements," National Conference of State Legislatures, Health Policy Tracking Service, as of 23 July 2001 (unpublished data, specifically collected for the *Report Card*).

[249] Moreover, about 40 percent of the state Medicaid programs do not offer pregnant women, who may not be good candidates for nicotine replacement therapy (e.g., gum, the patch, nasal spray), any coverage for behavioral cessation programs while they are pregnant or breastfeeding. Helen Halpin Schauffler and others, *Medicaid Coverage for Tobacco Dependence Treatments* (Princeton: Robert Wood Johnson Foundation, 1999), 16.

[250] ***Data Source: Tobacco Sales Rate to Minors (%), FY 2000.*** Center for Substance Abuse and Prevention, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, "State Non-Compliance Rate Change Analysis Table, FFY 1999-2000" [Online]; Available: WWW URL: http://www.samhsa.gov/centers/csap/SYNAR/01synartable.html, accessed 27 September 2001.

[251] Centers for Disease Control and Prevention, "Tobacco Use," 28 July 1999 [Online]; Available: WWW URL: http://www.cdc.gov/od/owh/whtob.htm, accessed 27 September 2001.

[252] From 1991 to 1997, smoking increased by 80 percent among African American high school students and by 34 percent among Hispanic students. Centers for Disease Control and Prevention, *Tobacco Use Among U.S. Racial/Ethnic Minority Groups: A Report of the Surgeon General 1998* (Atlanta: Centers for Disease Control and Prevention, Office on Smoking and Health, 1998), iii.

[253] Joseph R. DiFranza, "Are the Federal and State Governments Complying With the Synar Amendment?" *Archives of Pediatric & Adolescent Medicine* 153 (October 1999), 1089-1097.

[254] Joseph R. DiFranza, "Are the Federal and State Governments Complying With the Synar Amendment?", *Archives of Pediatric & Adolescent Medicine* 153 (October 1999), 1089-1097. The source used for the 2000 *Report Card* included preliminary data placed New Hampshire in the limited policy category. Final data, published after the completion of the Report Card indicated that New Hampshire should have been in the meets policy category in the 2000 *Report Card*.

[255] In 1992, the federal government enacted a law known as the "Synar Amendment" to prohibit the sale of tobacco to minors. Alcohol, Drug Abuse, and Mental Health Agency Reorganization Act of 1992, § 1926, 42 U.S.C. § 300x-26. In particular, the law required states by 1994 to pass laws banning the sale of tobacco to anyone under age 18 and to enforce these laws in a way that can reasonably be expected to restrict minors' access, including random, unannounced inspections of retailers. Regulations issued by the U.S. Department of Health and Human Services in 1996 set as a goal a 20 percent annual sales rate to minors. 66 *Federal Register* 46225-01, 4 September 2001. As a way to ensure states' compliance, the law requires the U.S. Department of Health and Human Services to reduce states' block grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) by a certain percentage for all subsequent years for which the state is out of compliance.

[256] National Center for Tobacco-Free Kids, "Comprehensive Statewide Tobacco Prevention Programs Effectively Reduce Tobacco Use," 20 November 1999 [Online]; Available: WWW URL: http://tobaccofreekids.org/research/factsheets/ pdf/0045.pdf, accessed 9 October 2001.

[257] ***Data Source: Laws Restricting Indoor Smoking (Environmental Tobacco Smoke), 2000.*** Cassandra Welch, ed., *State Legislated Actions on Tobacco Issues* (Washington, D.C.: American Lung Association, 2000). EXPLANATION: The complete list of places of public access included in this indicator are: arts/cultural facilities, elevators, gyms/arenas, jury/courtrooms, public meetings, public transit, restrooms, retail/grocery stores, and shopping centers. "Comprehensive" (meets policy) means that the state prohibits smoking in all of the areas and any designated smoking areas must be separately enclosed and ventilated to the outside. "Extensive" (limited policy) means that the state prohibits smoking in day care centers and schools, requires restrictions in restaurants, and in general prohibits or restricts smoking in public areas. "Moderate" (weak policy) means that the state prohibits or restricts smoking in schools, and the state has more than a minimal number of restrictions in public places. "Minimal" (no policy) means that the state has no complete prohibition of smoking in any of the areas. "None" means there are no restrictions on smoking in any of the areas.

[258] A Group A carcinogen is a severe classification traditionally reserved for the most dangerous of cancer-causing substances, such as asbestos and radon. Office of Research and Development, *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders* (Washington, D.C.: U.S. Environmental Protection Agency, Office of Research and Development, 1992), 101, 105.

[259] Office of Research and Development, *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders* (Washington, D.C.: U.S. Environmental Protection Agency, Office of Research and Development, 1992), 1.

[260] ***Data Source: Smoking Excise Tax ($), 2000.*** Cassandra Welch, ed., "Appendix D: States Cigarette Excise Tax, 2000," in *State Legislated Actions on Tobacco Issues* (Washington, D.C.: American Lung Association, 2000).

[261] Michael Grossman and others, "Cigarette Taxes: The Straw to Break the Camel's Back," *Public Health Reports* 112 (July/August 1997), 295; see also Frank J. Chaloupka and Kenneth E. Warner, "The Economic Analysis of Cigarette Smoking," in *The Handbook of Health Economics*, eds. Joseph P. Newhouse and others (Amsterdam North-Holland 2000).

[262] Centers for Disease Control and Prevention, Office on Smoking and Health, *Best Practices for Comprehensive Tobacco Control Programs* (Atlanta: Centers for Disease Control and Prevention, August 1999), 85.

[263] ***Data Source: State Funding for Tobacco Prevention, 2000.*** Campaign for Tobacco-Free Kids and others, "Appendix A: Rankings by Level of State Funding for Tobacco Prevention," in *Show Us the Money: An Update on the States' Allocation of the Tobacco Settlement Dollars* (Washington, D.C.: Campaign for Tobacco Free Kids and others, 2001).

[264] According to the CDC, the goal of such programs is to reduce disease, disability, and death related to tobacco use by: (1) preventing young people from starting to use tobacco; (2) promoting quitting among young people and adults; (3) eliminating nonsmokers' exposure to environmental tobacco smoke (also known as "second-hand smoke"); and (4) identifying and eliminating the disparities related to tobacco use and its effects among different population groups. Centers for Disease Control and Prevention, Office on Smoking and Health, *Best Practices for Comprehensive Tobacco Control Programs* (Atlanta: Centers for Disease Control and Prevention, August 1999), 3.

[265] Centers for Disease Control and Prevention, Office on Smoking and Health, *Best Practices for Comprehensive Tobacco Control Programs* (Atlanta: Centers for Disease Control and Prevention, August 1999).

[266] Centers for Disease Control and Prevention, Office on Smoking and Health, *Investment in Tobacco Control: State Highlights—2001* (Atlanta: Centers for Disease Control and Prevention, 2001), v.

[267] For many states, the primary source of funding is the tobacco settlement monies.

[268] ***Data Source: Binge Drinking (%), 1999, (state race/ethnicity and age 1997, 1999).*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *1999 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1997),Table 16.2, 47 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who reported having five or more drinks on at least one occasion in the last month. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico. Data for race/ethnicity and age at the state level are two-year averages from 1997 and 1999 (except for AK, CA, DC, ID, IL, OA, NV, NM, OK, TN, WI, which include 1998 data, and are age adjusted to the 2000) standard age population. National Center for Health Statistics, *State Health Statistics by Sex and Race/Ethnicity: Health Behavior and Risk Factor Tables* [Online]; Available: WWW URL: http://www.cdc.gov/nchs/statestatsbysexrace.htm, accessed 20 July 2001.

[269] *Healthy People 2010*, 26-32.

[270] *Healthy People 2010*, Objective 26-11c.

[271] ***Data Source: Annual Dental Visits (%), 1999.*** BRFSS 1999, [Online]; Available: WWW URL: http://apps.nccd.cdc.gov/ brfss/sex.asp?cat=OH&yr=1999&qkey=6610&state=US; Centers for Disease Control and Prevention. EXPLANATION: This new status indicator measure includes women age 18 and over in the non-institutionalized civilian population who reported visiting the dentist or dental clinic within the past year for any reason. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico.

[272] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General—Executive Summary* (Rockville: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000).

[273] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General—Executive Summary* (Rockville: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000), vii.

[274] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General—Executive Summary* (Rockville: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000), vii.

[275] *Healthy People 2000*, Objective 13.14.

[276] ***Data Source: Diabetes Control Program, 2001.*** "Data about Comprehensive and Core Capacity Programs from the Centers for Disease Control and Prevention," 23 April 2001 [Online]; Available: WWW URL: http://www.cdc.gov/diabetes/states/index.htm, accessed 26 September 2001. Data about state-supplemented funding were obtained from Linda Hurst, Program Services Branch, Diabetes Control Program, Centers for Disease Control and Prevention, 24 September 2001.

[277] Centers for Disease Control and Prevention, *Core Versus Comprehensive Assistance*, May 2000, [Online]; Available: WWW URL: http://www.cdc.gov/diabetes/states/assist.htm, accessed 24 September 2001.

[278] ***Data Source, Arthritis Program, FY 2001:*** Arthritis Foundation, "FY 2002 Arthritis Program: Centers for Disease Control & Prevention," unpublished issue brief, October 2001. Conversation and Correspondence with Dr. Joe Sniezek, Arthritis Program Chief, Health Care and Aging Studies Branch, Centers for Disease Control and Prevention, 1-3 October 2001.

[279] The description of this indicator changed due to the CDC's changes to the program funding structure in FY2001. In its first round of funding in FY1999, the CDC awarded eight four-year grants to states with existing arthritis programs which were referred to as "core" grants averaging $320,000 and were referred to in the 2000 *Report Card* as Level I grants. This year's funding for "enhanced establishment" grants (the lower level of funding) reflects an increase of double the average amount of $60,000 awarded under the FY1999 "establishment" grants, which were referred to in the 2000 *Report Card* as Level II grants.

[280] There was no change this year because these grants are for four years and will continue until 2003.

[281] ***Data Source: Osteoporosis Public Education, FY1999.*** National Osteoporosis Foundation (NOF), *Survey of State Activities on Osteoporosis in 1998* (Washington, D.C.: NOF, 1999). Data were updated in conversation with David Pfau, NOF, April 2000.

[282] National Osteoporosis Foundation, *Survey of State Activities on Osteoporosis in 1998* (Washington, D.C.: National Osteoporosis Foundation, 1998).

[283] *Healthy People 2010*, Objective 9-11.

[284] U.S. Surgeon General Dr. David Satcher, *The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior* (Washington, D.C.: U.S. Dept. of Health and Human Services, June 2001).

[285] Another recent report confirmed that programs that include information on contraception do not increase sexual activity, and some have been shown to reduce or delay sexual activity. Douglas Kirby, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* (Washington, D.C.: The National Campaign to Prevent Teen Pregnancy, May 2001).

[286] While the *Report Card* credits such states for laws with the content requirements described by NARAL's *Who Decides?*, neither NARAL nor NWLC endorses these states' programs as necessarily adequate. See *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, at 275.

[287] States that pass a policy requiring either that (a) sexuality education include both contraception and abstinence or (b) STD/HIV education include abstinence and other methods of prevention are described as having a limited policy. Because many of the same preventive methods are found in either policy, there is a significant impact on both pregnancy and disease prevention when either policy is in place. Therefore, to describe a state that has passed either one of these policies as having a weak policy does not adequately describe the state's effort.

[288] ***Data Source: Sexuality Education, 2000.*** NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2001); NARAL and NARAL Foundation, *The Status of Sexuality and STD/HIV Education in the States* (Washington, D.C.: NARAL and NARAL Foundation, 2001).

[289] Abstinence-until-marriage curricula are not included, as such curricula have been demonstrated to be ineffective with adolescents. Debra W. Haffner, *Sexuality Information and Education Council of the United States (SIECUS) Report: What's Wrong with Abstinence-Only Sexuality Education Programs?* 25 (April/May 1997).

[290] The source for the 2000 *Report Card* categorized Hawaii's sexuality education as optional. NARAL discussions with state officials have made clear that Hawaii mandates sexuality education, and also mandated it for the time period covered for the 2000 *Report Card*. Conversation with Jodi Michael, NARAL, July 2001.

[291] ***Data Source: STD/HIV Education, 2000.*** NARAL and NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 10th ed. (Washington, D.C.: NARAL and NARAL Foundation, 2001); NARAL and NARAL Foundation, *The Status of Sexuality and STD/HIV Education in the States* (Washington, D.C.: NARAL and NARAL Foundation, 2001).

[292] Abstinence-until-marriage curricula are not included, as such curricula have been demonstrated to be ineffective with adolescents. Debra W. Haffner, *Sexuality Information and Education Council of the United States (SIECUS) Report: What's Wrong with Abstinence-Only Sexuality Education Programs?* 25 (April/May 1997).

[293] States that pass a policy requiring either that (a) sexuality education include both contraception and abstinence or (b) STD/HIV education include abstinence and other methods of prevention are described as having a limited policy. Because many of the same preventive methods are found in either policy, there is a significant impact on both pregnancy and disease prevention when either policy is in place. Therefore, to describe a state that has passed either one of these policies as having a weak policy does not adequately describe the state's effort.

[294] ***Data Source: Heart Disease (rate per 100,000 people), 1996-1998.*** Special data run for the *Report Card*, National Center for Health Statistics (NCHS), June 14, 2001. EXPLANATION: The heart disease death rates for women are three-year averages, per 100,000 estimated population. The denominator for the 1995-1997 data was constructed differently than the denominator for the 1996-1998 data. The denominator used in the rate calculation for the 1995-1997 data was the 1997 U.S. Census Bureau population estimate. The mid-year of the 1997 population estimate was multiplied by three and used in the denominator in the calculation of the rate for the deaths that occurred in 1995-1997; the denominator used in the rate calculation for the 1996-1998 data was the sum of the U.S. Census Bureau estimates for the years 1996-1998. Although the denominators were constructed differently for the data years 1995-1997 and 1996-1998, the differences are expected to be small. Due to periodic revisions of the population estimates by the U.S. Census Bureau, more recent replication of the rates may differ slightly due to more current revisions in the population estimates (possibly more so in smaller groups). Communication with National Center for Health Statistics, October 5, 2001. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 1940 standard population. The *International Classification of Diseases, Ninth Revision* (ICD-9) code definitions are taken from established NCHS cause-of-death tabulations. For heart disease deaths, the ICD-9 codes used by NCHS cause-of-death tabulations definition (390-398, 402, 404-429) differs from that used to track Healthy People 2000 (402, 410-414, 429.2).

[295] American Heart Association, *2001 Heart and Stroke Statistical Update* (Dallas: American Heart Association, 2000), 12.

[296] American Heart Association, "Facts About Women and Cardiovascular Diseases," 2000 [Online]; Available: WWW URL: http://www.women.americanheart.org/stroke/fs_facts.html, accessed 30 September 2001 (38 percent of women versus 25 percent of men die within one year of a heart attack).

[297] *Healthy People 2000*, Objective 15.1.

[298] ***Status Indicator: Stroke (rate per 100,000 people), 1996-1998.*** Special data run for the *Report Card*, National Center for Health Statistics (NCHS), June 14, 2001. NCHS data currently are published age-adjusted to the 2000 standard population. EXPLANATION: "Stroke" and "Cerebrovascular Disease" are used interchangeably in the *Report Card*, and refer to the same ICD-9 codes (430-438). "Stroke" is used in accordance with the definition of the American Heart Association. American Heart Association, *1999 Heart and Stroke Statistical Update* (Dallas: American Heart Association, 1998). Death rates for women are three-year averages, per 100,000 estimated population. The denominator for the 1995-1997 data was constructed differently than the denominator for the 1996-1998 data. The denominator used in the rate calculation for the 1995-1997 data was the 1997 U.S. Census Bureau population estimate. The mid-year of the 1997 population estimate was multiplied by three and used in the denominator in the calculation of the rate for the deaths that occurred in 1995-1997; the denominator used in the rate calculation for the 1996-1998 data was the sum of the U.S. Census Bureau estimates for the years 1996-1998. Although the denominators were constructed differently for the data years 1995-1997 and 1996-1998, the differences are expected to be small. Due to periodic revisions of the population estimates by the U.S. Census Bureau, more recent replication of the rates may differ slightly due to more current revisions in the population estimates (possibly more so in smaller groups). Communication with National Center for Health Statistics, October 5, 2001. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 1940 standard population.

[299] National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data By State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM] (includes women of all ages, years 1995 to 1997).

[300] National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data By State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM] (includes women of all ages, years 1995 to 1997).

[301] *Healthy People 2000*, Objective 15.2.

[302] ***Data Source: Lung Cancer (rate per 100,000 people), 1996-1998.*** Special data run for the *Report Card*, National Center for Health Statistics, June 14, 2001. NCHS data currently are published age-adjusted to the 2000 standard population. EXPLANATION: Lung cancer includes malignant neoplasms of the trachea, bronchus and lung. Lung cancer death rates for women are three-year averages, per 100,000 estimated population. The denominator for the 1995-1997 data was constructed differently than the denominator for the 1996-1998 data. The denominator used in the rate calculation for the 1995-1997 data was the 1997 U.S. Census Bureau population estimate. The mid-

year of the 1997 population estimate was multiplied by three and used in the denominator in the calculation of the rate for the deaths that occurred in 1995-1997; the denominator used in the rate calculation for the 1996-1998 data was the sum of the U.S. Census Bureau estimates for the years 1996-1998. Although the denominators were constructed differently for the data years 1995-1997 and 1996-1998, the differences are expected to be small. Due to periodic revisions of the population estimates by the U.S. Census Bureau, more recent replication of the rates may differ slightly due to more current revisions in the population estimates (possibly more so in smaller groups). Communication with National Center for Health Statistics, October 5, 2001. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 1940 standard population. The *International Classification of Diseases, Ninth Revision* (ICD-9) code definitions are taken from established NCHS cause-of-death tabulations. For lung cancer deaths, the ICD-9 codes used by NCHS cause-of-death definition (162) differs slightly from that used to track Healthy People 2000 (162.2-162.9).

303 National Center for Health Statistics, Center for Disease Control and Prevention, Women's Health Data By State and U.S. Territory: Mortality 1994-97 (Hyattsville: National Center for Health Statistics, Center for Disease Control and Prevention, September 1999)[CD-ROM] (includes women of all ages, years 1995 to 1997).

304 Anna H. Wu, "Epidemiology of Lung Cancer in Women," in *Women & Health*, eds. Marlene B. Goldman and Maureen C. Hatch (San Diego: Academic Press, 2000), 949.

305 *Healthy People 2000*, Objective 16.2a.

306 ***Data Source: Breast Cancer (rate per 100,000 people), 1996-1998.*** Special data run for the *Report Card*, National Center for Health Statistics, June 14, 2001. NCHS data currently are published age-adjusted to the 2000 standard population. EXPLANATION: Breast cancer death rates for women are three-year averages, per 100,000 estimated population. The denominator for the 1995-1997 data was constructed differently than the denominator for the 1996-1998 data. The denominator used in the rate calculation for the 1995-1997 data was the 1997 U.S. census Bureau population estimate. The mid-year of the 1997 population estimate was multiplied by 3 and used in the denominator in the calculation of the rate for the deaths that occurred in 1995-1997, the denominator used in the rate calculation for the 1996-1998 data was the sum of the U.S. Census Bureau estimates for the years 1996-1998. Although the denominators were constructed differently for the data years 1995-1997 and 1996-1998, the differences are expected to be small. Due to periodic revisions of the population estimates by the U.S. Census Bureau, more recent replication of the rates may differ slightly due to more current revisions in the population estimates (possibly more so in smaller groups). Communication with National Center for Health Statistics, October 5, 2001. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 1940 standard population.

307 National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data By State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM] (includes women of all ages, years 1995 to 1997).

308 Robert T. Greenlee and others, "Cancer Statistics 2000," *CA-A Cancer Journal for Clinicians* 50 (2000), 7-33.

309 *Healthy People 2000*, Objective 16.3.

310 The Breast and Cervical Cancer Mortality Prevention Act, 42 U.S.C. § 300k.

311 ***Data Source: High Blood Pressure (%), 1999 (state race/ethnicity and age 1997, 1999).*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *1999 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1997) Table 8.2, 23 [Online]; Available; WWW URL; http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. Data for race/ethnicity and age at the state level are two-year averages from 1997 and 1999 (except for CA, IL, IA, ND, OH, OK, TN, VA, WI, WY, which include 1998 data), and are age adjusted to the 2000 standard age population. National Center for Health Statistics, *State Health Statistics by Sex and Race/Ethnicity: Health Behavior and Risk factor Tables* [Online]; Available: WWW URL: http://www.cdc.gov/nchs/statestatsbysexrace.htm, accessed 20 July 2001. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who reported having ever been told by a health care professional that they have high blood pressure. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico.

312 *Healthy People 2010*, Objective 12-9.

313 ***Data Source: Diabetes (%), 2000 (state race/ethnicity and age 1997-1999) (national race/ethnicity data 1992-1994).*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *2000 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000), Table 7.2, 20 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. Data for race/ethnicity and age at the *state* level are three-year averages from 1997 to 1999 and are age adjusted to the 2000 standard age population. National Center for Health Statistics, *State Health Statistics by Sex and Race/Ethnicity: Health Behavior and Risk factor Tables* [Online]; Available: WWW URL: http://www.cdc.gov/nchs/statestatsbysexrace.htm, accessed 20 July 2001. Data for race/ethnicity at the *national* level are from Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention, " *Journal of American Medical Women's Association* 53 (Spring 1998), 96-107. EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who reported ever being told by a doctor that they have diabetes. In the *Report Card*, the Healthy People 2000 goal was converted to a percentage (e.g., 25 per 1,000 was converted to 2.5 percent) to grade this indicator. *National*: The national number is the median of all 50 states, the District of Columbia and Puerto Rico.

314 *Healthy People 2000*, Objective 2.24.

315 Paulo A. Lotufo and others, "Diabetes in Women," in *Women & Health*, eds. Marlene B. Goldman and Maureen C. Hatch (San Diego: Academic Press, 2000), 826.

316 ***Data Source: AIDS (rate per 100,000 people), 2000.*** Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report* 12 (2001), Fig. 2, 12. Data for race/ethnicity at the national level are from Table 18, 28. EXPLANATION: This measure includes female adult/adolescent (age 13 and over) annual AIDS rates per 100,000 women, for cases reported in 2000. *National:* The national number includes the 50 states, the District of Columbia and U.S. territories.

317 Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, *HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk*, September 2000 [Online]; Available: WWW URL: http://www.cdc.gov/hiv/pubs/facts/women.pdf, accessed 30 September 2001 (includes females age 13 and above).

318 Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, *HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk*, September 2000 [Online]; Available: WWW URL: http://www.cdc.gov/hiv/pubs/facts/women.pdf, accessed 30 September 2001.

[319] *Healthy People 2000*, Objective 18.1d.

[320] ***Data Source: Arthritis (National Only) (%), 1998.*** Special data run for the *Report Card*, National Center for Health Statistics, June 14, 2001 from the 1998 *National Health Interview Survey* (NHIS). EXPLANATION: This measure includes women age 18 and over in the non-institutionalized civilian population who responded that they had pain, aching, stiffness within the past year and reported that these symptoms were present most days for at least one month in the National Health Interview Survey during 1998. Data are age adjusted to the 2000 standard population.

[321] Special data run for the *Report Card*, *National Center for Health Statistics*, 1998 National Health Interview Survey, 14 June 2001.

[322] Centers for Disease Control and Prevention, "Prevalence and Impact of Arthritis Among Women – United States, 1989-1991," *Morbidity and Mortality Weekly Report* 44 (5 May 1995), 329-334.

[323] ***Data Source: Osteoporosis (National Only) (%), 1988-1991.*** Anne C. Looker and others, "Prevalence of Low Femoral Bone Density in Older U.S. Women," *Journal of Bone and Mineral Research* 10 (5 November 1995), 796-802. Using *National Health and Nutritional Examination Survey* (NHANES III). EXPLANATION: The prevalence of osteoporosis in the non-institutionalized civilian population age 50 and over is based on World Health Organization (WHO) diagnostic criteria. Estimates of low femoral bone density are based on dual-energy X-ray absorptiometry (DXA) measurements of femoral BMD.

[324] *Healthy People 2010*, 2-5; Agency for Healthcare Research and Quality, *Osteoporosis in Postmenopausal Women: Diagnosis and Monitoring*, February 2001. [Online]; Available: WWW URL: http://www.ahrq.gov/clinic/osteosum.htm, accessed 15 October 2001.

[325] *Healthy People 2010*, Objective 2-9.

[326] ***Data Source: Chlamydia (%), 1999.*** Division of Sexually Transmitted Diseases and Prevention, *Sexually Transmitted Disease Surveillance 1999 Supplement: Chlamydia Prevalence Monitoring Project* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, September, 2000), Figure 3, 11. EXPLANATION: This measure includes females age 15 to 24 testing positive for chlamydia in family planning clinics. Data were obtained through routine screening of women at family planning clinics. The percentage of women testing positive was calculated by dividing the number of women testing positive for chlamydia by the total number of women tested for chlamydia. Not all states use the same tests, and test sensitivity varies. The denominator may contain multiple tests from the same individual if that person was tested more than once during a year. States reported chlamydia positivity data on at least 500 women age 15 to 24 years screened during 1999 except for Rhode Island. *National:* The national number is the median of all 50 states and the District of Columbia.

[327] Rita Mangione-Smith and others, "Health and Cost Benefits of Chlamydia Screening in Young Women," *Sexually Transmitted Diseases* (July 1999), 309-316.

[328] Division of Sexually Transmitted Diseases and Prevention, *Sexually Transmitted Disease Surveillance, 1999* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, September 2000), 7: Agency for Healthcare Research and Quality, *Screening for Chlamydial Infection: Recommendations and Rationale* [Online]; Available WWW URL: http://www.ahrq.gov/clinic/ajpmsuppl/chlarr.htm, accessed 12 October 2001.

[329] Rita Mangione-Smith and others, "Health and Cost-Benefits of Chlamydia Screening in Young Women," *Sexually Transmitted Diseases* (July 1999), 309-316.

[330] *Healthy People 2000*, Objective 19.2.

[331] ***Data Source: Unintended Pregnancy (National Only) (%), 1994.*** Stanley K. Henshaw, "Unintended Pregnancy in the United States," *Family Planning Perspectives* 30 (January/February 1998), 24-29, 46. EXPLANATION: This measure includes women age 15 to 44 who had an unintended pregnancy in 1994. Data from the 1995 National Survey of Family Growth (NSFG) and from other sources are used to provide estimates, for 1994, on the percentage of pregnancies that were unintended. The estimated proportion of women who have ever had an unintended pregnancy is calculated by first adding the number of women who had an unplanned birth to the number who had had an abortion, and then subtracting those who were counted twice because they had had both an unplanned birth and an abortion.

[332] Stanley K. Henshaw, "Unintended Pregnancy in the United States," *Family Planning Perspectives* 30 (January/February 1998), 24-29, 46.

[333] Stanley K. Henshaw, "Unintended Pregnancy in the United States," *Family Planning Perspectives* 30 (January/February 1998), 24-29, 46.

[334] *Healthy People 2000*, Objective 5.2.

[335] ***Data Source: Maternal Mortality (ratio per 100,000 live born infants), 1987-1996.*** Centers for Disease Control and Prevention, "State-Specific Maternal Mortality Among Black and White Women – United States, 1987-1996," *Morbidity and Mortality Weekly Report* 48 (18 June 1999), 492-496. EXPLANATION: Maternal mortality data are from Centers for Disease Control and Prevention's National Center for Health Statistics, and have been aggregated to include data from 1987 through 1996. Aggregation is necessary to control for the unreliability of the small values. The maternal mortality ratio is not based on the total population, but rather on deaths per 100,000 live-born infants. Note, however, that the numerator includes some maternal deaths that were not related to live-born infants and thus were not included in the denominator. Although more recent data at the national level are available, the *Report Card* uses national level data that are consistent with the data years available at the state level.

[336] Centers for Disease Control and Prevention, "State-Specific Maternal Mortality Among Black and White Women – United States, 1987-1996," *Morbidity and Mortality Weekly Report* 48 (18 June 1999), 492-496; Centers for Disease Control and Prevention, "Maternal Mortality – United States, 1982-1996," *Morbidity and Mortality Weekly Report* 47 (4 September 1998), 705-707.

[337] Centers for Disease Control and Prevention, "State-Specific Maternal Mortality Among Black and White Women – United States, 1987-1996," *Morbidity and Mortality Weekly Report* 48 (18 June 1999), 492-496.

[338] *Healthy People 2000*, Objective 14.1.

[339] ***Data Source: Days Mental Health Was "Not Good" (%), 2000.*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *2000 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000), Table 3.2, 8 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/brfss/pubrfdat.htm, accessed 16 July 2001. EXPLANATION: This measure includes the mean number of days during the past 30 days that women age 18 and over in the non-institutionalized civilian population report that their mental health was "not good." *National:* The national number is the median of the 50 states, the District of Columbia and Puerto Rico.

[340] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999), 5-6.

[341] ***Data Source: Violence Against Women (National Only) (%), 1995-1996.*** Patricia Tjaden, *Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey* (Atlanta: National Institute of Justice, Centers for Disease Control and Prevention, 1998), 2, 5-6. EXPLANATION: These data are for women age 18 and over in the non-institutionalized civilian population and include lifetime experiences of rape and/or physical assaults. The survey defines "rape" as an event (either attempted or completed) that occurs without the victim's consent, that involves the use or threat of force to penetrate the victim's vagina or anus by penis, tongue, fingers or object, or the victim's mouth by penis. The survey defines "physical assault" as behaviors that threaten, attempt, or actually inflict harm, ranging from slapping and hitting to using a gun. For physical assaults experienced by children, however, the survey only asks about such conduct if engaged in by adult caretakers (not other people), while for adults, it includes this behavior by any perpetrator.

[342] ***Data Source: Life Expectancy (years), 1989-1991.*** National Center for Health Statistics (NCHS), U.S. *Decennial Life Tables for 1989-1991* Vol. II, *State Life Tables, Alabama* No. 1 (Hyattsville: National Center for Health Statistics, 1998), 4. EXPLANATION: This measure is women's life expectancy at birth (in years) for 1989-1991. The life tables (in the NCHS report) are current life tables based on age-specific death rates for the period 1989-1991. With the exception of those age 95 and over, the death rates were calculated using state data from the 1990 Census for the years 1989-1991 and were based on residency at the time of death. Because state life tables are not currently produced on an annual basis, the decennial life tables are the only source of state life expectancy data available at the National Center for Health Statistics. Although more recent data at the national level are available, the *Report Card* uses national level data that are consistent with the data years available at the state level.

[343] *Healthy People 2010*, 9.

[344] *Ibid.*

[345] ***Data Source: Days Activities Were Limited in Past 30 Days (%), 2000.*** Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *2000 BRFSS Summary Prevalence Report* (Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000), Table 4.2, 11 [Online]; Available: WWW URL: http://www.cdc.gov/nccdphp/ brfss/pubrfdat.htm, accessed 16 July 2001. EXPLANATION: This measure includes the mean number of days during the past 30 days that women in the non-institutionalized civilian population age 18 and over report not being able to perform their usual activities due to poor physical or mental health. *National:* The national number is the median of all 50 states, the District of Columbia and Puerto Rico.

[346] ***Data Source: Infant Mortality (rate per 1,000 live births), 1996-1998.*** National Center for Health Statistics, *National Vital Statistics Report* 48 (20 July 2000), Table 1, 9. EXPLANATION: This measure is the number of deaths occurring to infants under one year of age per 1,000 live births. *National:* The national number includes data for all 50 states and the District of Columbia.

[347] *Healthy People 2010*, 16-17.

[348] *Ibid.*

[349] *Healthy People 2000*, Objective 14.1.

[350] Due primarily to the "welfare reform" of the mid-1990s, The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), 42 U.S.C. §§ 601-609, states now have developed highly individualized programs that are difficult to compare.

[351] ***Data Source: Poverty (%), 1998 and 1999.*** U.S. Bureau of Labor Statistics and U.S. Census Bureau, *Current Population Survey, March 1999 and March 2000 Supplements* (Washington, D.C.: U.S. Census Bureau, 1999, 2000) (databases) (unpublished data analyses by Decision Demographics for the *Report Card*). To compensate for small sample size, Decision Demographics combined the applicable data from the two supplements to arrive at more reliable estimates. EXPLANATION: The measure is based on total family income level, and includes all civilian, non-institutionalized women age 18 and over who live in a family whose income falls below the federal poverty threshold. Following the Office of Management and Budget's (OMB) Statistical Policy Directive 14, the U.S. Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty. If a family's total income is less than the threshold that corresponds to that family's size and composition, then that family, and every individual in it, is considered in poverty. The official poverty definition counts money income before taxes and does not include capital gains and noncash benefits (such as public housing, Medicaid, and food stamps). Joseph Dalaker and Bernadette D. Proctor, *Poverty in the United States: 1999* (Washington, D.C.: U.S. Government Printing Office, 2000), vii.

[352] U.S. Bureau of Labor Statistics and the Bureau of the Census, *Current Population Survey, March 1998 and March 1999 Supplements* (Washington, D.C.: U.S. Census Bureau, 1998, 1999) (databases) (unpublished data analysis by Decision Demographics). To compensate for small sample size, Decision Demographics combined the applicable data from the two supplements and averaged them to arrive at more reliable estimates.

[353] ***Data Source: Wage Gap (%), 1996-1998.*** Institute for Women's Policy Research, *The Status of Women in the States*, 3rd ed. (Washington, D.C.: Institute for Women's Policy Research, 2000-2001), 79. EXPLANATION: The wage gap is a term used to describe the difference of median annual income earned by non-institutionalized women and men age 16 and over who worked full-time, year-round (more than 49 weeks during the year and more than 34 hours per week) in 1996 to 1998. It is a ratio of the median earnings of women to those of men. The analysis in the cited report was based on calculations by the Economic Policy Institute (using the 1997-1999 Annual Demographics Files) from the *Current Population Survey*, U.S. Census Bureau.

[354] ***Data Source: High School Completion (%), 1999 and 2000.*** U.S. Bureau of Labor Statistics and U.S. Census Bureau, *Current Population Survey, March 1999 and March 2000 Supplements* (Washington, D.C.: U.S. Census Bureau, 1999, 2000) (databases) (unpublished data analyses by Decision Demographics for the *Report Card*). To compensate for small sample size, Decision Demographics combined the applicable data from the two supplements to arrive at more reliable estimates. EXPLANATION: This indicator measures the percent of civilian, non-institutionalized women age 22 and over who are high school graduates. This includes those who have earned a high school diploma or equivalent (such as a GED) or any higher degree. In addition, information about the percentage of civilian, non-institutionalized women age 25 and over who have some college or an Associate degree, and those with a Bachelor's degree is provided in the demographic profile for each state. The indicator is graded based on the Healthy People 2010 Objective 7-1 to increase high school completion to 90 percent of people age 18 to 24. To increase the sample size, the *Report Card* uses data for women age 22 and over.

[355] *Healthy People 2010*, 7-13.

[356] *Healthy People 2010*, Objective 7-1.

[357] ***Data Source: Child Support Pass-Through, 1999.*** Paula Roberts, *State Policy Re: Pass-through and Disregard of Current Month's Child Support Collected for Families Receiving TANF-Funded Cash Assistance* (Washington, D.C.: Center for

Law and Social Policy, January 1999) [Online]; Available: WWW URL: http://www.clasp.org/pubs/childenforce/1999cht.htm, accessed 13 August 2001.

[358] Elaine Sorenson and Chava Zibman, *To What Extent Do Children Benefit From Child Support?* (Washington, D.C.: The Urban Institute, 1999), 7.

[359] 42 U.S.C. § 657(a)(1)(A).

[360] 42 U.S.C. § 657(a)(1)(B).

[361] The *Report Card* categorizes West Virginia as having a pass-through even though it does not have pass-through provisions per se, since TANF grants are increased by up to $50 a month for those on whose behalf current support is collected.

[362] The *Report Card* does not consider Iowa to have the pass-through policy because Iowa permits only families who received a pass-through before 1996 to continue to receive a pass-through until they are no longer receiving assistance.

[363] ***Data Source: Child Support Collection (%), 2000.*** Administration for Children and Families, Office of Child Support Enforcement, Division of Policy and Planning, *FY2000 Preliminary Data Preview Report*, Table 1.7. Statistical Program Status (Washington, D.C.: U.S. Department of Health and Human Services, July 2001). EXPLANATION: The percentage of collection is determined by dividing the number of cases with some successful collection by the number of cases requiring collection. This method does not identify how the percentage of child support is actually collected in a particular "successful" collection.

[364] Elaine Sorenson and Chava Zibman, *To What Extent Do Children Benefit From Child Support?* (Washington, D.C.: The Urban Institute, 1999), 7.

[365] The Administration for Children and Families notes that improved data reporting required by federal law makes some comparisons between data collected before and after FY 1999 difficult. Administration for Children and Families, Office of Child Support Enforcement, Division of Policy and Planning, *FY2000 Preliminary Data Preview Report*, Preface (Washington, D.C.: U.S. Department of Health and Human Services, July 2001). Advocates note, however, that the general upward trend observed since FY 1998 is an accurate reflection of states' improved efforts in child support collection, and not just improved reporting. Conversation with Joan Entmacher, Vice President, Family Economic Security, National Women's Law Center, August 2001.

[366] ***Data Source: State Supplement of SSI Grant, 2001.*** U.S. Social Security Administration, *A Desktop Guide to SSI Eligibility Requirements, SSI State Supplements*, SSA Publication No. 05-11001 (Washington, D.C.: Social Security Administration, January 2001, revised July 2001) [Online]; Available: WWW URL: http://www.ssa.gov/pubs/11001.html, accessed 13 August 2001. EXPLANATION: "Aged" is defined as 65 or older. "Blindness" is defined as "corrected vision of 20/200 or less in better eye or field of vision less than 20 degrees." "Disability" is defined as "a physical or mental impairment that keeps a person from performing any 'substantial' work, and is expected to last 12 months or result in death." 42 U.S.C. §§ 1382c(a)(1), 1382c(a)(2), 1382c(a)(3). Delaware and Montana are categorized as not having supplements, because supplements are available only to persons in "protective care" arrangements. In Delaware, protective care arrangements are for people "living in an approved adult residential care facility." In Montana, the facilities include: personal care facilities; group homes for the mentally disabled or mentally ill; community homes for the physically or developmentally disabled; child and adult foster care; and transitional living services for the developmentally disabled. U.S. Social Security Administration, *State Assistance Programs for SSI Recipients January 2000* (Washington, D.C.: Social Security Administration, July 2000), 19-20, 60-61 [Online]; Available: WWW URL: http://www.ssa.gov/ statistics/ssi_sap/2000/statessi.pdf, accessed 8 August 2001.

[367] Social Security Bulletin "Annual Statistical Supplement, 2000, Table 7.E3.—Number and Percentage Distribution of Persons Receiving Federally Administered Payments, by Sex, Age, and Category, December 1999" (Washington, D.C.: Social Security Administration, 2000), 279 [Online]; Available: WWW URL: http://www.ssa.gov/statistics/Supplement/2000/7e.pdf, accessed 16 August 2001. SSI is a federal program that makes monthly cash payments to the elderly, the blind and people with disabilities, and provides the primary means of financial assistance to these individuals when they have limited income and resources. 42 U.S.C. § 1381 *et seq*.

[368] U.S. Social Security Administration, *State Assistance Programs for SSI Recipients January 2000* (Washington, D.C.: Social Security Administration, July 2000), vii [Online]; Available: WWW URL: http://www.ssa.gov/statistics/ssi_sap/2000/statessi.pdf, accessed 8 August 2001.

[369] ***Data Source: Percentage of Income Paid in State and Local Taxes (%), 1995.*** Michael Ettinger and others, *Who Pays? A Distributional Analysis of the Tax Systems in All 50 States, Appendix I: Detailed State-by-State Tables* (Washington, D.C.: Citizens for Tax Justice and The Institute on Taxation & Economic Policy, 1996) [Online]; Available: WWW URL: http://www.ctj.org/html/whopay.htm, accessed 13 August 2001. EXPLANATION: Taxes are state and local taxes, and include sales, excise, property, and income taxes. Data look at the share of family income for non-elderly and married couples. Tax credits are included in the calculation of state income taxes. *Ibid.*, App. V, 2.

[370] Michael Ettlinger and others, *Who Pays? A Distributional Analysis of the Tax Systems in All 50 States* (Washington, D.C.: Citizens for Tax Justice and The Institute on Taxation & Economic Policy, June 1996).

[371] ***Data Source: Minimum Wage ($), 2000.*** U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, *Minimum Wage and Overtime Premium Pay Standards Applicable to Nonsupervisory Nonfarm Private Sector Employment Under State and Federal Laws* (Washington, D.C.: U.S. Department of Labor, January 2001).

[372] Jared Bernstein, *The Next Step: The New Minimum Wage Proposal and The Old Opposition* (Washington, D.C.: Economic Policy Institute, April 1999), 3, Table 1 (stating that 59.2 percent of low wage earners are women). Estimates of the number of women whose incomes would increase due to raising the minimum wage range from 13 to 30 percent. AFL-CIO, *Millions of Workers Benefit When the Minimum Wage is Raised* (January 2000) [Online]; Available: WWW URL: http://www.aflcio.org/articles/minimum_wage/myths_1.htm, accessed 9 August 2001 (30 percent); Jared Bernstein and others, *The Minimum Wage Increase: A Working Woman's Issue* (Washington, D.C.: Economic Policy Institute and Institute for Women's Policy Research, September 1999), 1 (nearly 13 percent).

[373] For this indicator, the *Report Card* uses the federal poverty threshold. The preliminary estimate of the weighted average poverty threshold for a family of three for 2000 is $13,737. U.S. Department of Commerce, Bureau of the Census, *Preliminary Estimate of Weighted Average Poverty Thresholds for 2000.* [Online] Available: WWW URL: http://www.census.gov/hhes/poverty/threshld/00prelim.html, accessed 9 August 2001. This estimated poverty threshold is divided by 2080 (40 hours per week times 52 weeks per year) to obtain the $6.61 benchmark. This means that a person working full-time, year-round would need to earn $6.61 per hour for her family of three to reach the estimated poverty threshold for 2000.

[374] U.S. Department of Labor, Employment Standards Administration, *The Minimum Wage*, May 2000 [Online]; Available: WWW URL: http://www.dol.gov/dol/esa/public/minwage/main.htm, accessed 9 August 2001.

[375] The raising of the minimum wage in Connecticut and California will not take effect until 1 January 2002.

[376] Although in these seven states employers generally must pay at least the federal minimum wage for all workers covered by the federal law, they may pay lower amounts for the small number of workers exempt from federal coverage, such as babysitters, companions for the elderly, disabled workers, or switchboard operators. U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, *FLSA Advisor: Exemptions* [Online]; Available: WWW URL: http://www.elaws.dol.gov/flsa/screen75.asp, accessed 9 August 2001.

[377] The 2000 *Report Card* incorrectly reported that Michigan had laws against discrimination; in fact it did not. In addition, the source for the 2000 *Report Card* mistakenly reported that Missouri had not enacted legislation protecting against genetic discrimination; in fact it had enacted legislation in both the insurance and employment contexts. Missouri therefore was also a part of this group of states in the 2000 *Report Card*.

[378] ***Data Source: Employment Anti-Discrimination and Sexual Orientation, 2001.*** Human Rights Campaign, "Non-Discrimination in the Workplace," undated [Online]; Available: WWW URL: http://www.hrc.org/worknet/, accessed 26 June 2001, data updated daily per Daryl Herrshaft, Worknet Manager, Human Rights Campaign. The source used for the 2000 *Report Card* incorrectly described Michigan; in fact, it had no policy.

[379] Bureau of National Affairs, Inc., "Race Religion and National Origin Provisions," August 1997, in *BNA Policy and Practice Series: Fair Employment Practices* (Washington, D.C.: Bureau of National Affairs, Inc., 1998), 30-32; Bureau of National Affairs, Inc., "Sex, Marital Status, and Equal Pay Provisions," August 1997, in *BNA Policy and Practice Series: Fair Employment Practices* (Washington, D.C.: Bureau of National Affairs, Inc., 1998), 33-35; Bureau of National Affairs, Inc., "Age and Disability Provisions," August 1997, in *BNA Policy and Practice Series: Fair Employment Practices* (Washington, D.C.: Bureau of National Affairs, Inc., 1998), 36-38.

[380] ***Data Source: Policy Indicator: Genetic Anti-Discrimination, 2000.*** National Human Genome Research Institute, "Genetic Information and Health Insurance Enacted Legislation" [Online] Available: www.nhgri.nih.gov/Policy_and_public_affairs/Legislation/insure.htm, accessed 24 August 2001.

[381] Executive Order 13,145 (8 February 2000).

[382] *Who Dies? A Look at Firearms Death and Injury in America – Revised Edition: Females and Firearms Violence* (Washington, D.C.: Violence Policy Center, February 1999) [Online]; Available: WWW URL: http://www.vpc.org/studies/whofem.htm, accessed 7 August 2001.

[383] *Who Dies? A Look at Firearms Death and Injury in America – Revised Edition: Females and Firearms Violence* (Washington, D.C.: Violence Policy Center, February 1999) [Online]; Available: WWW URL: http://www.vpc.org/studies/whofem.htm, accessed 7 August 2001.

[384] D.C. Code § 7-2501.01 *et seq.*

[385] ***Data Source: Licensing/Permits and Waiting Periods, 2001.*** Brady Campaign to End Gun Violence (formerly known as Handgun Control) [Online]; Available: WWW URL: http://www.bradycampaign.org/facts/statelaws, accessed 8 July 2001, information current as of January 2001. EXPLANATION: For the District of Columbia, see D.C. Code § 7-2501.01 *et seq.* Because Washington, D.C. bans all handguns entirely, the *Report Card* considers it to have adopted each of the handgun polices below even though, technically, it did not adopt the specific requirements.

[386] ***Data Source: Safe Storage and Safety Locks, 2001.*** Brady Campaign to End Gun Violence (formerly known as Handgun Control) [Online]; Available: WWW URL: http://www.bradycampaign.org/facts/statelaws, accessed 8 July 2001, information current as of January 2001. EXPLANATION: For the District of Columbia, see D.C. Code § 7-2501.01 *et seq.* Because Washington, D.C. bans all handguns entirely, the *Report Card* considers it to have adopted each of the handgun polices below even though, technically, it did not adopt the specific requirements.

[387] ***Data Source: Concealed Weapons Prohibition, 2001.*** Brady Campaign to End Gun Violence (formerly known as Handgun Control) [Online]; Available: WWW URL: http://www.bradycampaign.org/facts/statelaws, accessed 8 July 2001, information current as of January 2001. For the District of Columbia, see D.C. Code § 7-2501.01 *et seq.* EXPLANATION: Because Washington, D.C. bans all handguns entirely, the *Report Card* considers it to have adopted each of the handgun polices below even though, technically, it did not adopt the specific requirements.

[388] Brady Campaign & Brady Center to Prevent Handgun Violence (formerly known as Handgun Control & the Center to Prevent Handgun Violence), *Concealed Weapons, Concealed Risk* 12 June 2001 [Online]; Available: WWW URL: http:// http://www.bradycampaign.org/facts/issuebriefs/ccw.asp, accessed 7 August 2001.

[389] States that do not prohibit the carrying of concealed weapons generally have either "may issue" or "shall issue" policies on the issuing of concealed weapon licenses or permits, allowing less and more access to these licenses or permits, respectively. The *Report Card* does not consider "shall issue" policies to limit a resident's ability to carry concealed weapons, since these policies generally require the issuing of concealed weapon licenses or permits to any applicant who has reached a minimum age and is not a felon.

[390] *Healthy People 2010*, 8-4.

[391] ***Data Source: Monitoring Potentially Environment-Related Diseases/Conditions, 1997.*** Centers for Disease Control and Prevention, "Monitoring Environmental Disease—United States, 1997," *Morbidity Mortality Weekly Report* 47 (3 July 1998), 522-525 [Online]; Available: WWW URL: http://www.cdc.gov/mmwr/preview/mmwrhtml/00053687.htm, accessed 24 September 2001. Perri Zeitz and others, "1997 CSTE-CDC-ASPH Survey of Statewide Surveillance Systems of Sentinel Environmental Diseases: Status and Trends," Table A-1. Information available: WWW URL: http://www.cste.org/archive_may97.htm, accessed 24 September 2001. EXPLANATION: States are evaluated based on whether they monitor the following diseases/conditions: (1) childhood and adult lead poisoning (counted only if both are monitored); (2) mercury poisoning; (3) pesticide poisoning; (4) carbon monoxide poisoning; (5) acute chemical poisoning; and (6) asthma.

[392] *Healthy People 2010*, Objective 8-27.

[393] See Society for the Advancement of Women's Health Research, *Women's Health Research and the Environment* (Washington, D.C.: Society for the Advancement of Women's Health Research, 1994), 12-13 (discussing evidence that women may store and release lead differently than men do); Ruth H. Allen, "Evidence for the Role of Environment in Women's Health: Geographical and Temporal Trends in Health Indicators," in *Women & Health*, eds. Marlene B. Goldman and Maureen C. Hatch (San Diego: Academic Press, 2000), 607-624 (discussing the significance of "endocrine disruptors" for women often found in pesticides); U.S. PIRG Education Fund and others, *Fishing for Trouble: A Survey of Mercury Contamination in America's Waterways* (Washington, D.C.: U.S. PIRG, 1999) (discussing the effects of mercury poisoning); Ellen K. Silbergeld, "The Environment and Women's Health: An Overview," in *Women & Health*, eds. Marlene B. Goldman and Maureen C. Hatch (San Diego: Academic Press, 2000), 601-606.

[394] ***Data Source: Per Capita (Urban Resident) Spending on Public Transit ($), 1993-1997.*** Sierra Club, Solving Sprawl: The Sierra Club Rates the States (San Francisco: Sierra Club, 1999), 15-18. Data were analyzed further in contact with Deron Lovaas, Sierra Club, September 1999 through March 2000. EXPLANATION: States are evaluated based on their use not only of state funds, but also of federal and local funds, since states have broad discretion on how to spend transportation-directed resources. The data cover spending for the most recent five-year period available (1993-1997) and include only capital, not operating, costs. The "per capita" is based on systems serving urbanized populations (50,000 or more people). The District of Columbia is not included in this indicator because the Sierra Club did not calculate transit spending for the District of Columbia, and such an analysis was not readily available.

[395] For example, states can enact laws that reduce the injuries from transportation-related accidents, including state seat belt laws and state drunk driving laws. National Highway Traffic Safety Administration, Presidential Initiative for Increasing Seat Belt Use Nationwide: Recommendations from the Secretary of Transportation [Online]; Available: WWW URL: http://www.nhtsa.dot.gov/people/injury/airbags/presbelt, accessed 24 September 2001. In 1999, 13,667 women were killed nationwide in motor vehicle accidents. Fatality Analysis Reporting System (FARS), National Highway Traffic Safety Administration [Online]; Available: WWW URL: http://www-fars.nhtsa.dot.gov/main.cfm, accessed 24 September 2001.

[396] One way to ensure that low-income women see health care providers is for states to provide Medicaid payments for transportation to medical providers. See Community Transportation Association of America (CTAA), *Managing Medicaid Transportation: A Manual Examining Innovative Service Delivery Models Under State Medicaid Managed Care Plans* (Washington, D.C.: National Transit Resource Center, 2000), 5-6; Louise Brookins, *What's Wrong with the Medical Assistance Transportation Program and Why Must It Change Under Health Choices* (Pittsburgh: Pennsylvania Health Law Project, 1998).