NOTES

Report Card Findings

[1] For the purposes of the *Report Card*, the District of Columbia is included as a state, although it does not constitutionally hold that status.

Chapter I

[1] For the purposes of the *Report Card*, the District of Columbia is included as a state, although it does not constitutionally hold that status.

[2] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173, signed by President George W. Bush on December 8, 2003, available online at http://thomas.loc.gov/cgi-bin/bdquery/z?d108:h.4.00001:

[3] *Federal Register* 67 (October 2, 2002), 61956.

Chapter II

[1] Unless otherwise noted, national data are from the national report card in Chapter I and/or the chart for leading causes of death for all women on page 134. For a discussion of the grading methodology used to assess these health status indicators, see the Methodology section.

[2] Alina Salganicoff and others, *Women's Health in the United States: Health Coverage and Access to Care* (Menlo Park: The Henry J. Kaiser Family Foundation, May 2002), vii, available at http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14153, accessed March 10, 2004.

[3] *Ibid.*, xi.

[4] U.S. Department of Health and Human Services, *Healthy People 2010*, 2nd ed. (Washington: U.S. Department of Health and Human Services, 2000), Objective 1-1, available at http://www.health.gov/healthypeople, accessed March 10, 2004 [hereinafter *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] For this indicator, the *Report Card* presents the complementary data in order to be consistent with the benchmark.

[6] The term "institutionalized population" as used in the *Report Card* includes persons "under formally authorized, supervised care or custody, such as in federal or state prisons; local jails; federal detention centers; juvenile institutions; nursing, convalescent, and rest homes for the aged and dependent; and homes, schools, hospitals or wards for the physically handicapped, mentally retarded, or mentally ill." U.S. Census Bureau, Census of Population and Housing, 1990: Summary Tape File 3, Technical Documentation (Washington: U.S. Census Bureau, 1992) [CD-ROM].

[7] AARP, *Reforming the Health Care System: State Profiles, 2000* (Washington: AARP, 2000), 9.

[8] AARP, *Reforming the Health Care System: State Profiles, 2003* (Washington: AARP, 2003), viii-ix.

[9] *Healthy People 2010, supra* note 4, at 1-7, 1-8.

[10] See, e.g., Lorrine Thompson, "Health Care in Crisis: Medicaid Patients Still Can't Find Care," *The Olympian*, June 30, 2002, available at http://www.theolympian.com/home/specialsections/HealthCareinCrisis/20020630/7753.shtml, accessed March 5, 2004.

[11] *Healthy People 2010, supra* note 4, at 16-28.

[12] *Ibid.*; National Institutes of Health, *Women of Color Health Data Book* (Bethesda: National Institutes of Health, Office of the Director, undated), 64, available at http://www.4woman.gov/owh/pub/woc/figure23.htm, accessed March 5, 2004.

[13] *Healthy People 2010, supra* note 4, Objective 16-6a.

[14] Stanley K. Henshaw and Lawrence B. Finer, "The Accessibility of Abortion Services in the United States, 2001," *Perspectives on Sexual and Reproductive Health* 35 (January/February 2003), 16, available at http://www.guttmacher.org/pubs/journals/3501603.pdf, accessed March 10, 2004 (source for all preceding in paragraph).

[15] Physicians for Reproductive Choice and Health and The Alan Guttmacher Institute, "An Overview of Abortion in the United States," January 2003, available at http://www.guttmacher.org/pubs/abslides/abort_slides.pdf, accessed March 10, 2004.

[16] U.S. Department of Health and Human Services, *Steps to a Healthier U.S.: A Program and Policy Perspective: The Power of Prevention* (Rockville: U.S. Department of Health and Human Services, 2003), available at http://www.healthierus.gov/steps/summit/prevportfolio/power/index.html, accessed March 10, 2004.

[17] *Ibid.*

[18] The American Cancer Society issued updated guidelines for cervical cancer screening in 2002. Among other things, these guidelines recommend that screening be performed every year if using traditional Pap tests, every two years if using the newer liquid-based Pap tests, and every two to three years for women age 30 and older who have had three consecutive normal Pap tests and do not have certain risk factors. For women age 70 and older who have had three or more consecutive normal Pap test results in the last ten years, the

guidelines allow a termination of screening. Debbie Saslow and others, "American Cancer Society Guideline for the Early Detection of Cervical Neoplasia and Cancer," *CA: A Cancer Journal for Clinicians* 52 (November/December 2002), 342-362.

19 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 (SS-6) (October 8, 1999).

20 *Healthy People 2010, supra* note 4, Objective 3-11b.

21 For this indicator, the *Report Card* presents the complementary data in order to be consistent with the benchmark.

22 See note 19 *supra*, as well as Chapter IV.

23 *Healthy People 2010, supra* note 4, Objective 3-13.

24 For this indicator, the *Report Card* presents the complementary data in order to be consistent with the benchmark.

25 National Center for Health Statistics, "Healthy Women: State Trends in Health and Mortality," available at http://www.cdc.gov/nchs.healthywomen.htm, accessed March 19, 2004.

26 *Healthy People 2010, supra* note 4, at 3-15.

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

28 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.

29 *Healthy People 2010, supra* note 4, Objective 3-12b.

30 *Healthy People 2010, supra* note 4, at 12-3.

31 *Healthy People 2010, supra* note 4, Objective 12-15.

32 For this indicator, the *Report Card* presents the complementary data in order to be consistent with the benchmark.

33 *Healthy People 2010, supra* note 4, at 22-3; womenshealthchannel, "Back Pain," January 9, 2004, available at http://www.womenshealthchannel.com/backpain/index.shtml.

34 *Healthy People 2010, supra* note 4, Objective 22-1.

35 U.S. Department of Health and Human Services, "Steps to a Healthier US," 2003, available at http://www.healthierus.gov/steps/steps_brochure.html, accessed February 10, 2004.

36 Alli H. Mokdad and others, "Actual Causes of Death in the United States, 2000," *Journal of the American Medical Association* 291 (March 10, 2004), 1240.

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

38 *Healthy People 2010, supra* note 4, Objective 19-2.

39 U.S. Department of Health and Human Services, U.S. Department of Agriculture, "Nutrition and Your Health: Dietary Guidelines for Americans," 2000, available at http://www.health.gov/dietaryguidelines/dga2000/document/build.htm#fruits, accessed March 22, 2004.

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

41 *Healthy People 2010, supra* note 4, Objectives 19-5, 19-6.

42 For this indicator, the *Report Card* presents the complementary data in order to be consistent with the benchmark.

43 U.S. Department of Health and Human Services, *Women and Smoking: A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, Office of the Surgeon General, 2001), iii, 7, available at http://www.surgeongeneral.gov/library, accessed March 10, 2004 [hereinafter *Women and Smoking: A Report of the Surgeon General*].

44 *Ibid.*, Chapter 2.

45 Current smoking for adults is defined as having ever smoked at least 100 cigarettes and smoking currently, and the measure includes women who smoke every day or only some days. Centers for Disease Control and Prevention, "Cigarette Smoking Among Adults—United States, 2000," *Morbidity and Mortality Weekly Report* 51 (July 26, 2002), 642-645. Current smoking for boys and girls is defined as any use within the past 30 days. Lloyd D. Johnston and others, "Teen Smoking Declines Sharply in 2002, More Than Offsetting Large Increases in the Early 1990s," December 16, 2002, Tables 2 and 3, available at http://monitoringthefuture.org/data/02data.html#2002data-cigs, accessed March 10, 2004.

46 *Healthy People 2010, supra* note 4, Objective 27-1a.

47 *Healthy People 2010, supra* note 4, at 26-4, 26-32.

48 *Healthy People 2010, supra* note 4, Objective 26-11c.

49 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, 2000).

50 *Ibid.*, vii.

51 *Healthy People 2010, supra* note 4, Objective 21-10.

52 American Heart Association, "Women and Cardiovascular Diseases," 2003, 5, available at http://www.americanheart.org/presenter.jhtml?identifier=3000941, accessed March 10, 2004.

53 American Heart Association, "Heart Disease and Stroke Statistics," 2003, available at http://www.americanheart.org/downloadable/heart/1075102824882HDSStats2004UpdateREV1-23-04.pdf, March 10, 2004.

54 American Heart Association, "Facts About Women and Cardiovascular Diseases," 2000, available at http://www.women.americanheart.org/stroke/fs_facts.html, accessed March 10, 2004 (38 percent of women versus 25 percent of men die within one year of a heart attack).

55 *Healthy People 2010, supra* note 4, Objective 12-1.

56 Centers for Disease Control and Prevention, "Deaths: Leading Causes for 2001," November 2003, available at http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_09.pdf; American Heart Association, "Women and Stroke," available at http://www.americanheart.org/presenter.jhtml?identifier=10871, accessed February 11, 2004.

57 *Healthy People 2010, supra* note 4, Objective 12-7.

58 *Women and Smoking: A Report of the Surgeon General, supra* note 43, at 209; American Heart Association and American Stroke Association, *Heart Disease and Stroke Statistics, 2003 Update* (Dallas: American Heart Association and American Stroke Association, 2003), 4.

59 *Healthy People 2010, supra* note 4, Objective 3-2.

60 American Cancer Society, *Cancer Facts and Figures 2003* (Atlanta: American Cancer Society, 2003), 4, available at http://www.cancer.org/downloads/STT/CAFF2003PWSecured.pdf [hereinafter *Cancer Facts 2003*].

61 The Breast Cancer Fund, "Breast Cancer Facts," 2003, available at http://www.breastcancerfund.org/disease_facts.htm, accessed March 10, 2004.

62 *Cancer Facts 2003, supra* note 60.

63 *Healthy People 2010, supra* note 4, Objective 3-3.

64 *Healthy People 2010, supra* note 4, at 12-4 to 12-8.

65 *Healthy People 2010, supra* note 4, Objective 12-9.

66 Centers for Disease Control and Prevention, *National Agenda for Public Health Action: A National Public Health Initiative on Diabetes and Women's Health* (Atlanta: Centers for Disease Control and Prevention, 2003), 14 (source for all information in paragraph).

67 *Healthy People 2010, supra* note 4, Objective 5-3.

68 Centers for Disease Control and Prevention, "Basic Statistics," *HIV/AIDS Surveillance Report*, December 2003, available at http://www.cdc.gov/hiv/stats.htm, accessed March 10, 2004.

69 Centers for Disease Control and Prevention. "HIV/AIDS Among US Women: Minority and Young Women at Continuing Risk," March 27, 2003, available at http://www.cdc.gov/hiv/pubs/facts/women.htm, accessed March 22, 2004. For more on women and HIV, see Chapter IV.

70 *Healthy People 2010, supra* note 4, Objective 13-1.

71 Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, "Who Has Arthritis?", available at http://www.cdc.gov/nccdphp/arthritis/index.htm, accessed March 10, 2004; *Healthy People 2010, supra* note 4, at 2-3; Centers for Disease Control and Prevention, "Prevalence of Self-Reported Arthritis Among Adults," 2001, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5142a2.htm#tab1, accessed March 5, 2004.

72 National Institutes of Health, Osteoporosis and Related Bone Diseases National Resource Center, "Fast Facts on Osteoporosis," available at http://www.osteo.org/newfile.asp?doc=fast&doctitle=Fast+Facts+on+Osteoporosis&doctype=HTML+Fact+Sheet, accessed March 5, 2004.

73 *Healthy People 2010, supra* note 4, at 2-5; Agency for Healthcare Research and Quality, *Osteoporosis in Postmenopausal Women: Diagnosis and Monitoring*, February 2001, available at http://www.ahrq.gov/clinic/osteosum.htm, accessed March 10, 2004.

74 The *Healthy People 2010* goal is reduce the number of osteoporosis cases to eight percent of adults age 50 and older (when applied to women). *Healthy People 2010, supra* note 4, Objective 2-9. However, because the *Report Card* grading methodology is based on the states' performance on each indicator, as explained in the Methodology section, it is not possible to grade the nation on this indicator in the absence of state data in a manner that is consistent with the rest of the *Report Card*.

75 Because more current data are not available for the nation, the national data from the 2001 *Report Card* have not been updated.

76 American Social Health Association, "Facts and Answers about STDs," 2001, available at http://www.ashastd.org/stdfaqs/chlamydia.html#howcommon, accessed March 10, 2004.

77 Division of Sexually Transmitted Diseases and Prevention, *Sexually Transmitted Disease Surveillance, 1999* (Atlanta: Centers for Disease Control and Prevention, September 2000), 7; Agency for Healthcare Research and Quality, "Screening for Chlamydial Infection: Recommendations and Rationale," available at http://www.ahrq.gov/clinic/ajpmsuppl/chlarr.htm, accessed March 10, 2004.

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

79 *Healthy People 2010, supra* note 4, Objective 25-1a.

80 As noted, more recent data for this indicator have become available at the national level only. The new overall figure for 2001 is 9.9 deaths per 100,000. Centers for Disease Control and Prevention, "Data 2010…The Healthy People 2010 Database—January 2004 Edition," available at http://wonder.cdc.gov/DATA2010\.

81 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 (June 18, 1999), 492-496; Centers for Disease Control and Prevention, "Pregnancy-Related Mortality Surveillance," February 2003, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5202a1.htm, accessed March 10, 2004.

82 World Health Organization, "Country Estimates of Numbers of Maternal Deaths, Lifetime Risk, Maternal Mortality and Ranges of Uncertainty," 1995, available at http://www3.who.int/whosis/mm/country_estimates_1995-mod.doc, accessed March 10, 2004.

83 *Healthy People 2010, supra* note 4, Objective 16-4.

84 Because more current state data are not available, the state and national data from the 2001 *Report Card* have not been updated.

85 *Healthy People 2010, supra* note 4, at 9-3. The National Survey of Family Growth classifies pregnancies in three categories: intended, mistimed, and unwanted, acknowledging that unintended pregnancies may or may not be unwanted pregnancies. Joyce C. Abma and others, "Fertility, Family Planning, and Women's Health: New Data from the 1995 National Survey of Family Growth," National Center for Health Statistics, *National Vital Health Statistics* 23 (May 1997).

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

87 The *Healthy People 2010* goal is to reduce unintended pregnancies to 30 percent or less of all pregnancies. *Healthy People 2010, supra* note 4, Objective 9-1. However, because the *Report Card* grading methodology is based on the states' performance on each indicator, as explained in the Methodology section, it is not possible to grade the nation on this indicator in the absence of state data in a manner that is consistent with the rest of the *Report Card*.

88 More current data are not available for the nation, therefore the national data from the 2001 *Report Card* have not been updated.

89 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, National Institute of Mental Health, 1999), 5-6.

90 Although more recent data for this indicator are available, the way in which they are now reported make them inconsistent with the *Report Card* format. Therefore, the data from the 2001 *Report Card* have not been updated.

91 The data from the 2001 *Report Card* have not been updated because more current data are not available.

92 Kevin Kinsella and Yvonne J. Gist, *International Brief: Gender and Aging: Mortality and Health* (Washington: U.S. Department of Commerce, Bureau of the Census, October 1998), 5, available at http://www.census.gov/ipc/prod/ib98-2.pdf, accessed March 10, 2004.

93 World Health Organization, "The World Health Report," 2003, available at http://www.who.int/whr/2003/en/Annex4-en.pdf, accessed March 10, 2004.

94 Because more current state data are not available, the state and national data from the 2001 *Report Card* have not been updated.

95 As noted in the data source, updated data are available for the nation. The updated overall national figure for 2001 for all women is 79.8 years. National Center for Health Statistics, "Table 12. Estimated Life Expectancy at Birth in Years, by Race and Sex: Death-Registration States, 1900-29, and United States, 1929-2001," *National Vital Statistics Report* 52 (February 18, 2004), 33-34.

96 Although more recent data for this indicator are available, the way in which they are now reported make them inconsistent with the *Report Card* format. Therefore, the data from the 2001 *Report Card* have not been updated.

[97] *Healthy People 2010, supra* note 4, 16-17.

[98] *Ibid.*

[99] *Healthy People 2010, supra* note 4, Objective 16-1c.

[100] U.S. Census Bureau, "Women and Men in the United States," March 2002, available at http://www.census.gov/prod/2003pubs/p20-544.pdf, accessed March 9, 2004. The federal poverty threshold for a family of three in 2002 was $14,348.

[101] For information on race and ethnicity data, see Data Source "Population of Females, by race, by age, and total" in Demographic Data Sources in the Methodology section.

[102] United States General Accounting Office, *Women's Earnings: Work Patterns Partially Explain Difference Between Men's and Women's Earnings*, October 2003, available at http://www.gao.gov/new.items/d0435.pdf, accessed March 9, 2004.

[103] *Healthy People 2010, supra* note 4, at 7-13.

[104] *Healthy People 2010, supra* note 4, Objective 7-1.

[105] For information on race and ethnicity data, see Data Source "Population of Females, by race, by age, and total" in Demographic Data Sources in the Methodology section.

Chapter III

[1] Alina Salganicoff and others, *Women's Health in the United States: Health Coverage and Access to Care* (Menlo Park: The Henry J. Kaiser Family Foundation, May 2002), ix, available at http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14153, accessed March 10, 2004 [hereinafter *Women's Health*].

[2] 42 U.S.C. §§ 1396-1396v; 42 C.F.R. Ch. IV; 45 C.F.R. Subtitle A.

[3] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured and Their Access to Health Care," May 2000, available at http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm &PageID=13335, accessed February 25, 2004. The federal poverty level for the purposes of this indicator is the U.S. Department of Health and Human Services' federal poverty guideline; this 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 and the Uninsured, *The Medicaid Resource Book* (Washington: The Henry J. Kaiser Family Foundation, July 2002), 12. The federal poverty level for 2003 is $15,260 for a family of three. *Federal Register* 68 (February 7, 2003), 6456-6458.

[4] U.S. Department of Health and Human Services, *Healthy People 2010*, 2nd ed. (Washington: U.S. Department of Health and Human Services, 2000), 16-28, available at http://www.health.gov/healthypeople , accessed March 10, 2004 [hereinafter *Healthy People 2010*] (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). 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] Jocelyn Guyer and others, *Taking the Next Step: States Can Now Expand Health Coverage to Low-Income Working Parents Through Medicaid* (Washington: Center on Budget and Policy Priorities, 1998), 1.

[6] Andy Schneider and others, *Medicaid Eligibility for Individuals with Disabilities* (Washington: Kaiser Commission on Medicaid and the Uninsured, 1999), 1, 3, 5.

[7] As of December 2003, Texas lowered its income eligibility level for pregnant women from 180 to 158 percent of the FPL. This does not change the way in which it is evaluated in the 2004 *Report Card*. Leighton Ku and Sashi Nimalendran, Center on Budget and Policy Priorities, "Losing Out: States are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs," December 22, 2003, available at http://www.cbpp.org/12-22-03health.htm, accessed March 10, 2004 [hereinafter Ku and Nimalendran].

[8] The federal minimum income at which states must cover single parents under Medicaid varies among states. Federal Medicaid law requires states to cover the aged and disabled who are eligible for Supplemental Security at 74 percent of FPL. The *Report Card* uses this number as its floor (i.e., "no policy"). 42 C.F.R. § 435.120 (except for certain states called 209(b) states, 42 C.F.R. § 435.121). The income threshold for SSI, and therefore for Medicaid coverage, is approximately 74 percent of the federal poverty level (FPL). Social Security Administration, "Understanding Supplemental Security Income," February 2004, available at http://www.ssa.gov/notices/ supplemental-security-income/text-eligibility-ussi.htm. FPL refers to the federal poverty guidelines for 2003, *Federal Register* 68 (February 7, 2003), 6456-6458.

[9] Massachusetts and New Jersey have implemented capped enrollment in their Medicaid programs for parents. Also, Missouri and Connecticut each reduced the eligibility level for parents within the range allowable for the limited category. Therefore, Missouri and Connecticut remain in the limited category in 2004, even though their Medicaid income eligibility level for parents has actually decreased. Ku and Nimalendran, *supra* note 7.

[10] "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).

[11] 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).

[12] Since the 2001 *Report Card*, Florida, New York and Vermont have lowered their eligibility levels. However, these decreases were within the range allowable for the limited category. Therefore, these three states remain in the limited category in 2004, even though their Medicaid income eligibility levels for the aged and disabled have actually decreased.

[13] Health Care Financing Agency (renamed Centers for Medicaid and Medicare Services, July 1, 2001), *Supporting Families in Transition: A Guide to Expanding Health Coverage in Post-Welfare Reform* (Washington: Health Care Financing Administration, 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: Center on Budget and Policy Priorities, 1998).

[14] Donna Cohen Ross and others, *Free & Low-Cost Health Insurance: Children You Know are Missing Out* (Washington: 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.

[15] Assets (or resources) refer to items of personal or real property. State Medicaid programs determine resource standards that are then measured against the individual's assets. If these assets are less than the standard, the individual meets the asset test. Assets that are countable are generally not homes, furniture or clothes. Savings accounts can be counted, although the entire value of the account is not always included. Cars can be counted, although this differs across states (i.e., some states do not count cars at all, some count only a second car, and others disregard a car up to a certain value). Generally, asset limits are very low, ranging from $1,000 to $6,000 dollars. 42 U.S.C. § 1396u-1(b)(2)(c); Kaiser Commission on Medicaid and the Uninsured, *Eliminating the Asset Test for Families: A Review of State Experiences* (Menlo Park: The Henry J. Kaiser Family Foundation, April 2001).

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

[17] 42 U.S.C. § 1396r-1 (states may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period); Centers for Medicare and Medicaid Services, "Optional Coverage of Categorically Needy Groups," in *State Medicaid Manual* § 3500.2, 1997, available at http://www.cms.hhs.gov/states/letters/wrcvi.asp, accessed February 25, 2004.

[18] Federal poverty level here refers to the 2003 federal poverty guideline.

[19] In the 2001 *Report Card*, states were not evaluated on whether their programs were statewide. Because this criterion is now taken into consideration, California goes from a "limited policy" to a "no policy" even with no actual change in its program. Similarly, two states—New Jersey and Michigan—were given a "no policy" because their programs were state funded and not waiver programs. The 2004 *Report Card* does not distinguish between programs providing coverage for this population through the Medicaid program (via a waiver) or with state-only funding. Any state program for childless, non-elderly, non-disabled adults could potentially qualify.

[20] Based on conversation with Karen Pollitz, Project Director, Institute for Health Care Research and Policy, Georgetown University, February 5, 2004.

[21] This is a new indicator for the 2004 *Report Card*.

[22] The "no policy" category for this indicator includes states that have some individual insurance market policies. However, these policies do not provide any real protection for individuals attempting to obtain insurance in this market.

[23] Jane Perkins and others, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, Second Edition (Los Angeles: National Health Law Program, 2003), 1. See also Chapter IV of the *Report Card* for further discussion of linguistic access for special groups of women.

[24] The Henry J. Kaiser Family Foundation, "Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare," January 2003, available at http://www.kff.org/medicare/upload/14361_1.pdf, accessed March 10, 2004.

[25] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 was signed into law on December 8, 2003. P.L. 108-173. The legislation provides some coverage for prescription drugs to older Americans, though the benefit structure is complex and some of the lowest income people may be worse off under it as compared to Medicaid. The 2001 *Report Card* evaluated state non-Medicaid pharmaceutical programs, which are pharmacy assistance programs to help ease the financial burden of buying prescription drugs for some low-income people. It is too early to determine whether states will retain or restructure their state programs in order to respond to gaps in the federal program. The 2004 *Report Card* therefore does not examine these state programs.

[26] For those elderly and disabled people that are dually eligible for Medicare and Medicaid, prescription drug coverage will be provided only through Medicare beginning in 2006 when the Medicare Prescription Drug, Improvement, and Modernization Act goes into effect. P.L. 108-173.

[27] Claudia Schlosberg and Sareena Jerath, National Health Law Program (NHeLP), "Fact Sheet: Prescription Drug Coverage Under Medicaid," July 1999, available at http://nhelp.org/pubs/19990808MedicaidDrugs.html, accessed March 10, 2004.

[28] In the wake of rising drug costs and state fiscal crises, 15 states have imposed waiting lists in the AIDS Drug Assistance Programs. Therefore, even with increased eligibility levels, ADAP is falling short of meeting the increasing demand for antiretroviral drugs. The Henry J. Kaiser Family Foundation, "More than 700 People on ADAP Waiting Lists; Program Needs $214 Million in New Funding, Advocates Say," *Kaiser Daily HIV/AIDS Report*, September 5, 2003, available at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=19711, accessed February 25, 2004.

[29] 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.

[30] Four states (Arkansas, Florida, New York, South Carolina) have limits on the number of prescriptions allowed per month and therefore they receive a "no policy." However, these states do provide exceptions or over-rides to their policy.

[31] *Women's Health, supra* note 1, at 41.

[32] "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, *The Policy Book: AARP Public Policies 2003* (Washington: AARP, 2003), available at http://assets.aarp.org/www.aarp.org_/articles/legislative/03ch7.pdf, accessed February 25, 2004 [hereinafter *AARP Public Policies 2003*].

[33] Centers for Disease Control and Prevention, National Center for Health Statistics, "The National Nursing Home Survey: 1999 Summary," June 2002, available at http://www.cdc.gov/nchs/data/series/sr_13/sr13_152.pdf.

[34] National Center for Health Statistics, "Health and Aging Chartbook," 1999, available at http://www.cdc.gov/nchs/data/hus/hus99.pdf, accessed March 10, 2004.

[35] *AARP Public Policies 2003, supra* note 32 (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 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).

[36] 42 U.S.C. § 3058g.

[37] For the "community spouse resource allowance," states must allow the community spouse to retain the greater of: (1) a minimum of $18,132 and a maximum of $90,660 in assets or (2) half the couple's joint assets up to $90,660. 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 $1,515 and no more than $2,267. Hawaii and Alaska are set higher because of a higher poverty level. *Federal Register* 68 (February 7, 2003), 6456-6458; Eric M. Carlson, *Long-Term Care Advocacy* (New York: Lexis Publishing, 2003), 7-133; 42 U.S.C. § 1396r-5(d).

[38] Institute of Medicine, *Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act* (Washington: National Academy Press, 1994), 175, Table 5.5d. The ratio of paid ombuds 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 ombuds 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,") 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 ombuds corps, the IOM report determined that the appropriate measure involved paid ombuds. The number used in the *Report Card* is for full-time equivalents (FTEs), i.e., not all of the ombuds serve this role in a full-time capacity.

[39] 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, National Institute of Mental Health, 1999), 227 [hereinafter *Mental Health: A Report of the Surgeon General*].

[40] *Ibid.*, 408, 418.

[41] *Ibid.*, 426.

[42] 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.

[43] *Healthy People 2010, supra* note 4, at 18-8.

[44] This disparity is true for major depression, anxiety disorders, and mood disorders. *Mental Health: A Report of the Surgeon General, supra* note 39, at 225-226.

[45] Rhode Island was evaluated incorrectly in the 2001 *Report Card*. It should have received a "meets policy" instead of a "no policy." Since there is no change in the individual state law for this state, the comparison with 2001 is based on the underlying data, that is, there is no change from 2001.

[46] Illinois, Nevada and Virginia were each incorrectly given a "no policy" in the 2001 *Report Card*. Illinois should have received a "limited policy," and Nevada and Virginia each should have received a "meets policy." Since there is no change in the individual state law for these three states, the comparison with 2001 is based on the underlying data, that is, there is no change from 2001.

[47] American Diabetes Association, "Diabetes Statistics for Women," undated, available at http://www.diabetes.org/diabetes-statistics/women.jsp, accessed February 2, 2004.

[48] American Cancer Society, *Cancer Facts and Figures 2003* (Atlanta: American Cancer Society, 2003), 4, available at http://www.cancer.org/downloads/STT/CAFF2003PWSecured.pdf [hereinafter *Cancer Facts 2003*].

[49] The Breast and Cervical Cancer 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.

[50] The National Breast and Cervical Cancer Early Detection Program 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 either disease. Breast and Cervical Cancer Mortality Prevention Act of 1990, 42 U.S.C. § 300k.

[51] 143 Cong. Rec. E159-01 (February 5, 1997) (Statement of Hon. Susan Molinari on the Women's Health and Cancer Rights Act of 1997).

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

[53] Due to a transcription error in the 2001 *Report Card*, Delaware was incorrectly given a "no policy" when it should have received a "meets policy." Michigan was incorrectly given a "no policy" in the 2001 *Report Card* because its statute required coverage of breast reconstructive surgery if recommended by a physician. Michigan should have received a "meets policy" regardless of this language. Since there is no change in the individual state law for these two states, the comparison with 2001 is based on the underlying data, that is, there is no change from 2001.

[54] Due to a transcription error in the 2001 *Report Card*, Maryland was incorrectly given a "limited policy." It should have received a "no policy." Since there is no change in the individual state law for this state, the comparison with 2001 is based on the underlying data, that is, there is no change from 2001.

[55] *Healthy People 2010, supra* note 4, at 9-14.

[56] In 1998, Congress passed legislation that requires contraceptive coverage for federal employees who are insured through the Federal Employees Health Benefits Plan (FEHBP). Such a policy has been shown to be cost-effective – for every dollar of public sector investments in contraceptive services, three dollars are saved in Medicaid costs for pregnancy-related health care and medical care for newborns. The Alan Guttmacher Institute, *The Cost of Contraceptive Insurance Coverage* (Washington: The Alan Guttmacher Institute, March 2003), available at http://www.agi-usa.org/pubs/ib_4-03.html, accessed February 5, 2004.

[57] Emergency contraception should not be confused with the early abortion option mifepristone, also known as RU-486. This FDA-approved drug terminates pregnancies of up to seven weeks, while emergency contraception prevents pregnancy after sexual intercourse. For more information, see NARAL Pro-Choice America "The Difference Between Emergency Contraception and Early Abortion Options (RU-486)," December 2003, available at http://www.prochoiceamerica.org/facts/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=6270, accessed March 19, 2004.

[58] *Healthy People 2010, supra* note 4, at 9-6, 9-7.

[59] Centers for Disease Control and Prevention, National Center for Health Statistics, "Fast Stats on Infertility," available at http://www.cdc.gov/nchs/fastats/fertile.htm, accessed March 10, 2004.

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

[61] This is a new indicator for the 2004 *Report Card*.

62 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).

63 The way in which this indicator is evaluated has changed from the 2001 *Report Card* and therefore there is no comparison to 2001. In 2001, the inclusion of religious restriction language in a state's law was not taken into consideration. The 2004 *Report Card* downgrades states for having a religious refusal clause that allows health insurers and/or employers to be exempted from the mandate based on religious or moral objections. With increasing numbers of affiliations between religious and secular health care institutions, this clause could potentially limit many patients' access to infertility treatments. Elena N. Cohen and Alison Sclater, *Truth or Consequences: Using Consumer Protection Laws to Expose Institutional Restrictions on Reproductive and Other Health Care* (Washington: National Women's Law Center, October 2003) 10-11, available at http://www.nwlc.org/pdf/TruthOrConsequences2003.pdf, accessed March 17, 2004.

64 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.

65 American Medical Association, "H-245.978 Impact of 24-Hour Postpartum Stay on Infant and Maternal Health," undated, at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-245.978.HTM, accessed February 13, 2004.

66 Vermont was evaluated incorrectly in the 2001 *Report Card*. It received a "meets policy," however, its mandate does not bind insurers to cover anything specific, but merely establishes guidelines for providers. Therefore, Vermont should have received a "no policy." Since there is no change in the individual state law for this state, the comparison with 2001 is based on the underlying data, that is, there is no change from 2001.

67 The Newborns' and Mothers' Health Promotion Act of 1996 requires group insurers that provide inpatient care following childbirth to provide coverage for a minimum of 48 hours for vaginal delivery and 96 hours for cesareans. 42 U.S.C. § 300gg-4. Although this federal law was passed to combat drive-through deliveries, state laws add the strength of state enforcement mechanisms.

68 *Roe v. Wade*, 410 U.S. 113 (1973).

69 The Alan Guttmacher Institute, "An Overview of Abortion in the United States," January 2003, available at http://www.guttmacher.org/pubs/abslides/abort_slides.pdf, accessed March 10, 2004.

70 Due to the atmosphere of intimidation and violence at many clinics, there is an escalating shortage of physicians willing to provide abortion services. NARAL Pro-choice America, "Clinic Violence and Intimidation," January 1, 2004, available at http://prochoiceamerica.org/facts/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=7850, accessed March 17, 2004. For current statistics on clinic violence, see National Abortion Federation, "Violence and Disruption Statistics," December 2003, available at http://www.prochoice.org/Violence/Statistics/stats.pdf, accessed February 27, 2004.

71 18 U.S.C. § 248.

72 National Abortion Federation, "Freedom of Access to Clinic Entrances Act," available at http://www.prochoice.org/Violence/Security/FACE.htm, accessed February 27, 2004.

73 146 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).

74 These bans are often referred to as "partial-birth" abortion bans. This term, developed by the anti-choice movement, is not a medical term and does not refer to any particular abortion procedure, including the late-term abortions it is supposed to describe. NARAL Pro-Choice America and NARAL Pro-Choice America Foundation, *Who Decides? A State-By-State Review of Abortion and Reproductive Rights*, 13th ed. (Washington: NARAL Pro-Choice America and NARAL Foundation, 2004), 5, available at http://www.prochoiceamerica.org/whodecides [hereinafter *Who Decides* 13th ed.].

75 On November 5, 2003, President Bush signed into law the Partial-Birth Abortion Ban Act of 2003—the first law ever to criminalize a legal medical procedure. P.L. 108-105.

76 In 2000, the Supreme Court struck down a similar ban as unconstitutional. *Stenberg v. Carhart,* 530 U.S. 914.

77 Some states also allow other adult relatives to give consent or receive notice. NARAL Pro-Choice America and NARAL Pro-Choice America Foundation, *Who Decides? A State-By-State Review of Abortion and Reproductive Rights Executive Summary*, 13th ed. (Washington: NARAL Pro-Choice America and NARAL Pro-Choice America Foundation, 2004), 83.

78 NARAL Pro-Choice America and NARAL Pro-Choice America Foundation, "Mandatory Parental Consent and Notice Laws Burden the Freedom to Choose," in *Who Decides* 13th ed., *supra* note 74, at 1.

79 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: The Alan Guttmacher Institute, 1990).

80 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.

81 Washington is the only state to meet policy because its law, similar to FACE, 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.

82 States that have parental involvement laws that have been enjoined or not enforced (as described in the NARAL data that is the source for this indicator) receive a "meets policy."

83 States with waiting period laws that have been enjoined or not enforced (as described in the NARAL data that is the source for this indicator) receive a "meets policy."

84 The *Report Card* gives states credit for meeting the policy even if they have been required by federal or state courts to provide funding.

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

86 Due to transcription errors in the 2001 *Report Card*, Maryland was incorrectly given a "limited policy" and New Hampshire was incorrectly given a "no policy." Maryland should have received a "no policy" and New Hampshire should have received a "limited policy." Since there is no change in the individual state law for these two states, the comparison with 2001 is based on the underlying data, that is, there is no change from 2001.

87 The data from the 2001 *Report Card* have not been updated.

88 The way in which states were evaluated for this indicator has changed from the 2001 *Report Card*; therefore, there is no comparison to 2001. Due to a lack of data, the 2004 *Report Card* does not evaluate laws on training for health care providers as it did in previous reports. This *Report Card* only evaluates states on training for police and prosecutors.

89 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.

90 AFL-CIO, "Family and Medical Leave," undated, available at www.aflcio.org/issuespolitics/worknfamily/fmla.cfm, accessed March 10, 2004.

91 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.

92 The way in which states were evaluated for this indicator has changed since the 2001 *Report Card* and therefore there is no comparison to 2001. The 2004 *Report Card* considers the "meets policy" category to be paid family and medical leave. In 2002, California became the first state in the nation to implement a paid leave policy. Funded through the State Disability Insurance program, the policy provides six weeks of partial pay to workers who take leave to care for a new child or an ill family member. Since California took this action, the trend in the states is towards enacting paid leave policies, as 27 states have introduced paid leave bills and five states have passed bills requiring that their legislatures research the costs of providing such leave. National Partnership for Women and Families, "Family Medical Leave Fact Sheet," undated, available at http://www.nationalpartnership.org/content.cfm?L1=202&DBT=Documents&NewsItemID=551&HeaderTitle=Family%20%26%20Medical%20Leave, accessed February 25, 2004.

93 *Ibid.*

94 National Partnership for Women and Families, "Making Family Leave More Affordable," 2002, available at http://nationalpartnership.org/content.cfm?L1=8&L2=1.0&GuideID=51&ArticleID=0, accessed February 27, 2004. Women with disabilities arising from pregnancy or childbirth can receive TDI, but only through the period of maternal disability and 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.

95 *Women's Health, supra* note 1.

96 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.

97 The way in which states were evaluated has changed for this indicator from the 2001 *Report Card*; therefore, there is no comparison to 2001. The 2001 *Report Card* was inconsistent in its grading of the "medically necessary" language. For the purposes of the 2004 *Report Card*, the definition of medically necessary has been clarified to include those provisions in the law that reference specific circumstances such as chronic conditions and degenerative conditions. If the law defines medically necessary as only referring to terminal illnesses, then the state does not satisfy the medically necessary criterion.

98 Optimally, managed care companies would be required to cover continued care with the provider for pregnant women regardless of when services began during the pregnancy. 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.

99 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).

100 Centers for Disease Control and Prevention, *The National Breast and Cervical Cancer Early Detection Program: At-A-Glance 1999* (Washington: 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) [hereinafter CDC *Early Detection Program*].

101 Maryland was evaluated incorrectly in the 2001 *Report Card*. It received a "no policy" because it had a regulation instead of a statute, however, it should have received a "meets policy." Since there is no change in the individual state law for this state, the comparison with 2001 is based on the underlying data, that is, there is no change from 2001.

102 American Social Health Association, "Facts and Answers about STDs," 2001, available at http://www.ashastd.org/stdfaqs/chlamydia.html#howcommon, accessed February 13, 2004.

103 U.S. Preventive Services Task Force, *Screening for Chlamydial Infection* (Rockville: U.S. Preventive Services Task Force, 2001), available at http://www.ahcpr.gov/clinic/prev/chlamwh.htm, accessed March 10, 2004; 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.

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

105 CDC *Early Detection Program, supra* note 100.

106 The *Report Card* uses annual screenings for women age 40 and older 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, "Cancer Detection Guidelines," January 2004, available at http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp? sitearea=PED, accessed February 27, 2004. 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, supra* note 4, Objective 3-13. Texas, Wyoming 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 Coverage Requirements," December 31, 2002.

107 In 2001, states were not given credit if their statutes required coverage of a mammogram "if recommended by a physician." The 2004 *Report Card* clarifies that this language qualifies states for the "meets" category. This change affects two states—Minnesota and Washington. Although each state received a "no policy" in 2001, Minnesota and Washington receive a "meets policy" in 2004. Furthermore, since there is no change in the individual state law, the comparison to 2001 for these two states is based on the underlying data, that is, there is no change from 2001. Similarly, Kansas was incorrectly given a "limited policy" in 2001. After reviewing its statute, the 2004 *Report Card* gives Kansas a "meets policy" and its comparison to 2001 is based on the underlying data.

[108] National Osteoporosis Foundation, "Bone Mass Measurement– Insurance Coverage," *Legislative Issue Brief* (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.

[109] 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 the efficacy of approved osteoporosis drug therapies. 42 U.S.C. § 1395x.

[110] Rhode Island was incorrectly marked as receiving a "meets policy" on the policy indicator chart in the 2001 *Report Card*, although it was correctly given a "no policy" in the text.

[111] *Cancer Facts 2003, supra* note 48, at 6.

[112] Colon Cancer Alliance, "Colorectal Cancer: Facts and Figures," 2003, available at http://www.ccalliance.org/pdfs/crcfact.pdf, accessed February 27, 2004.

[113] The *Report Card*'s evaluation does not distinguish by age, frequency of testing, type of testing or type of insurer.

[114] U.S. Department of Health and Human Services, *A Report of the Surgeon General: Physical Activity and Health – Adolescents and Young Adults*, available at http://fitness.gov/adoles.html, accessed February 13, 2004.

[115] 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 (March 7, 1997), 11-12.

[116] The way in which states are evaluated has changed from the 2001 *Report Card*; therefore, there is no comparison to 2001. In order to receive a "meets policy" in the 2004 *Report Card*, a state must mandate physical education for every year of high school enrollment, giving no regard to how much activity (daily, weekly, etc) is mandated. Mandating participation in PE for all four years of high school encourages students to make exercise a habit and to be physically active on a regular basis.

[117] The Centers for Disease Control and Prevention has recommended daily PE for students in kindergarten through twelfth grade, a reduction in the practice of granting exemptions for PE classes, and an increase in the amount of time that students are active in PE 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 (March 7, 1997), 11-12.

[118] Generally, individuals 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," April 2002, available at http://www.fns.usda.gov/fsp/applicant_recipients/facts_E.htm, accessed February 27, 2004.

[119] 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: Food Research and Action Center, February 2000), 1-2.

[120] U.S. Department of Health and Human Services, *Women and Smoking, A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, Office of the Surgeon General, 2001).

[121] Centers for Disease Control and Prevention, "Cigarette Smoking Among Adults—United States, 2000," *Morbidity and Mortality Weekly Report* 51 (July 26, 2002), 642-645.

[122] Task Force on Community Preventive Services, "Effectiveness of Reducing Patient Out-of-Pocket Costs for Effective Therapies to Stop Using Tobacco," in *Guide to Community Preventive Services* (2000), available at http://www.thecommunityguide.org/tobacco/, accessed March 10, 2004.

[123] 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. *Federal Register* 66 (September 4, 2001), 46225-46227. 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 by a certain percentage for all subsequent years for which the state is out of compliance.

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

[125] National Cancer Institute, "Population Based Smoking Cessation: Proceedings of a Conference on What Works to Influence Cessation in the General Population," *Smoking and Tobacco Control Monograph No. 12* (Bethesda: U.S. Department of Health and Human Services, National Cancer Institute, November 2000), at Chapter 3.

[126] Jeanne S. Ringel and William N. Evans, "Cigarette Taxes and Smoking During Pregnancy," *American Journal of Public Health* 91 (November 2001), 1851-1856.

[127] 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 [hereinafter CDC *Best Practices*].

[128] 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. *Ibid.*, 3.

[129] The 2002 National Youth Tobacco Survey conducted by the American Legacy Foundation revealed that youth smoking rates had seen a decrease during the two-year period when funding for state tobacco control programs were at their highest. Campaign for Tobacco Free Kids, "New Survey Showing Large Decline in High School Smoking is Proof that Tobacco Prevention Measures Work," November 13, 2003, available at http://www.tobaccofreekids.org/Script/DisplayPressRelease.php3?Display=709, accessed November 21, 2003.

[130] Each recommendation is based on specific characteristics of the state and is in the form of a range of funding, with a lower and upper estimate for the total annual cost of a comprehensive tobacco control program. CDC *Best Practices, supra* note 127, at 24.

[131] National Women's Law Center and Oregon Health & Science University, *Women and Smoking: A National and State-by-State Report Card* (Washington: National Women's Law Center, 2003), 21, available at http://www.nwlc.org/pdf/Women&SmokingReportCard2003.pdf, accessed March 10, 2004.

[132] In the 2001 *Report Card*, Virginia did not receive a grade for this indicator because the state did not respond to the survey that formed the basis of the data source that was used for this indicator in the 2001 *Report Card*. Therefore, there is no comparison with 2001 for Virginia for this *Report Card*.

[133] This is a new indicator for the 2004 *Report Card*.

[134] DiFranza, *supra* note 124.

[135] See note 123 *supra*.

[136] The way in which states are evaluated has changed for this indicator because the 2004 *Report Card* uses a different source than in 2001, therefore there is no comparison to 2001.

[137] Some states in this category also prohibit smoking in bars.

[138] A significant number of states in this category have designated nonsmoking areas restricting nonsmokers to one room or certain sections of a facility.

[139] The way in which states are evaluated has changed for this indicator from the 2001 *Report Card*; therefore, there is no comparison to 2001. The *Report Card* altered the policy standard by raising the "meets policy" category from states that have an excise tax of $1.00 and above to those with a tax of $1.50 and above. This change takes into account the trend towards rising excise taxes in the states as well as the fact that there is no set goal for this indicator (i.e. the higher the tax, the better). Research has shown that a ten percent increase in the price of cigarettes leads to an estimated seven percent reduction in teenage smoking and a four percent reduction in overall smoking. Frank J. Chaloupka and Kenneth E. Warner, "The Economics of Smoking," in *The Handbook of Health Economics*, eds. Anthony J. Cuyler and Joseph P. Newhouse (New York: North-Holland, Elsevier Science B.V., 2000), 1539-1627; Michael Grossman and others, "Cigarette Taxes: The Straw to Break the Camel's Back," *Public Health Reports* 112 (July/August 1997), 295; David Hopkins and others, "Review of Evidence Regarding Interventions to Reduce Tobacco Use and Exposure to Environmental Tobacco smoke," *American Journal of Preventive Medicine* 20 (2001), 29.

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

[141] The higher level of CDC funding is called Capacity Building Funding Category B. It has an average award of $300,000 to be used for training staff, expanding partnerships, increasing public awareness, strengthening surveillance, establishing advisory bodies, coordinating statewide arthritis activities and testing interventions. The lower level of funding is called Capacity Building Funding Category A and is, on average, about $120,000. It is to be used to lay the groundwork for arthritis activities by building partnerships and establishing surveillance and planning processes.

[142] *Healthy People 2010, supra* note 4, Objective 9-11.

[143] U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior* (Washington: U.S. Department of Health and Human Services, Office of the Surgeon General, June 2001).

[144] Abstinence-until-marriage curricula are not included, as such curricula have been demonstrated to be ineffective with adolescents. Debra W. Haffner, "What's Wrong with Abstinence-Only Sexuality Education Programs?" *Sexuality Information and Education Council of the United States (SIECUS) Report* 25 (April/May 1997), 9-13, available at http://www.siecus.org/siecusreport/volume25/25-4.pdf, accessed March 10, 2004.

[145] The way in which states are evaluated has changed for this indicator because the 2004 *Report Card* uses a different source than in 2001; therefore, there is no comparison to 2001.

[146] A 2001 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: The National Campaign to Prevent Teen Pregnancy, May 2001).

[147] The way in which states are evaluated has changed for this indicator because the 2004 *Report Card* uses a different source than in 2001; therefore, there is no comparison to 2001.

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

[149] 42 U.S.C. § 657(a)(1)(A).

[150] Additionally, this amount of child support, usually $50, is "disregarded" in calculating the amount of TANF assistance the family receives, so that 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. 42 U.S.C. § 657(a)(1)(B).

[151] Sorenson and Zibman, *supra* note 148.

[152] These policy changes include several measures under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, such as continued efforts to transform the child support information system, automate caseload processing and implement stricter new hire directives. These changes, coupled with earlier reforms in the 1980s, can help account for the increase in collection rates. For more information, see Elaine Sorensen and Ariel Halpern, "Child Support Enforcement is Working Better Than We Think," April 15, 2000, available at http://www.urban.org/ Template.cfm?NavMenuID=24&template=/TaggedContent/ViewPublication.cfm&PublicationID=6471, accessed February 10, 2004.

[153] 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* (Washington: U.S. Department of Health and Human Services, 2001), Preface. 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, January 2004.

[154] Social Security Administration, "SSI Annual Statistical Report," August 2003, available at http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2002/index.html, accessed February 13, 2004. 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.*

[155] Department of Labor Statistics, "Characteristics of Minimum Wage Workers," 2002, available at http://www.bls.gov/cps/minwage2002.htm, accessed March 10, 2004.

[156] The way in which states were evaluated has changed for this indicator from the 2001 *Report Card*; therefore, there is no comparison to 2001. In the 2001 *Report Card*, the "meets policy" category was determined to be a 40 percent collection rate, a rate which only a handful of states were achieving. States seem to be doing better on child support collection, due partly to administrative improvements in child support enforcement resulting from several policy

changes under welfare reform. After a lag time, states have begun using the newly-established enforcement tools of this law and subsequently seen their collection rates rise. Therefore, the 2004 *Report Card* raised the standard and defines the "meets policy" category as a collection rate of 60 percent or higher.

[157] 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.

[158] 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: Social Security Administration, July 2000), 19-20, 60-61, available at http://www.ssa.gov/policy/docs/progdesc/ssi_st_asst/2000/, accessed February 27, 2004.

[159] The data from the 2001 *Report Card* have not been updated.

[160] 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 2003 is $14,824. U.S. Census Bureau, "Poverty 2003," January 2004, available at http://www.census.gov/hhes/poverty/threshld/thresh03.html, accessed March 12, 2004. The poverty threshold is divided by 2080 (40 hours per week times 52 weeks per year) to obtain the $7.13 benchmark. This means that a person working full-time, year-round would need to earn $7.13 per hour for her family of three to reach the estimated poverty threshold for 2003.

[161] U.S. Department of Labor, "Minimum Wage," available at http://www.dol.gov/dol/topic/wages/minimumwage.htm, accessed February 27, 2004.

[162] For the seven states in the "no policy" category, employers generally must pay at least the federal minimum wage for all workers covered by federal law. However, they may pay lower amounts to the small number of workers exempt from federal coverage. A listing of the exemptions for the federal minimum wage mandate are available at http://www.twc.state.tx.us/news/efte/exemptions_from_minimum_wage_and_overtime.html

[163] Studies in 1994 and 1995 indicated that approximately one out of four insurance companies engaged in these practices, and one study (in 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. Terry Fromson and Nancy Durburow, *Insurance Discrimination Against Victims of Domestic Violence* (Harrisburg: Pennsylvania Coalition Against Domestic Violence Publications, 1998), 2 (updated with unpublished data from Terry Fromson, Women's Law Project, June 2001).

[164] *Ibid.*, 3-4.

[165] Bureau of National Affairs, Inc., "Race Religion and National Origin Provisions," August 1997, in *BNA Policy and Practice Series: Fair Employment Practices* (Washington: 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: 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: Bureau of National Affairs, Inc., 1998), 36-38.

[166] For further discussion of the disparities in health care for lesbians, see Chapter IV.

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

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

[169] Violence Policy Center, "Females and Firearms Violence," *Who Dies? A Look at Firearms Death and Injury in America – Revised Edition* (Washington: Violence Policy Center, February 1999) available at http://www.vpc.org/studies/whofem.htm, accessed March 10, 2004.

[170] *Ibid.*

[171] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, *Web-based Injury Statistics Query and Reporting System*, available at http://www.cdc.gov/ncipc/wisqars/default.htm, undated, accessed February 13, 2004.

[172] Brady Campaign to Prevent Gun Violence, "Concealed Weapons, Concealed Risk," June 12, 2001, available at http://www.bradycampaign.org/facts/issuebriefs/ccw.asp, accessed March 10, 2004.

[173] In each of the gun control indicators, the District of Columbia receives a "meets policy" because it has a complete ban on handguns (and therefore does not explicitly have these separate restrictions). D.C. Code § 7-2501.01 *et seq.*

[174] States that do not prohibit the carrying of concealed weapons generally have either "may issue" or "shall issue" policies on issuing 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 issuing concealed weapon licenses or permits to any applicant who has reached a minimum age and is not a felon.

[175] *Healthy People 2010, supra* note 4, at 8-4.

[176] *Healthy People 2010, supra* note 4, Objective 8-27.

[177] National Resources Defense Council, "Bush Mercury Policy Threatens the Health of Women and Children," February 2004.

[178] *Ibid.*

[179] See Society for the Advancement of Women's Health Research, *Women's Health Research and the Environment* (Washington: 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 Goldman *Women & Health, supra* note 104, at 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: U.S. PIRG, 1999) (discussing the effects of mercury poisoning); Ellen K. Silbergeld, "The Environment and Women's Health: An Overview," in Goldman *Women & Health, supra* note 104, at 601-606.

[180] The data from the 2001 *Report Card* have not been updated.

Chapter IV

Notes

1 As noted in Chapter II and in the Methodology section, data on race and ethnicity are collected inconsistently, with some data available only at either the state or national level, and thus are presented in only one or the other place as data are available. Mortality data presented on the charts in this chapter are from National Center for Health Statistics, "Healthy Women: State Trends in Health and Mortality," available at http://www.cdc.gov/nchs/healthywomen.htm, accessed January 20, 2004. Rates are three-year averages from 1999 to 2001 and are per 100,000 population. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 2000 standard population. Data on leading causes of death for all women can be found on page 134.

2 U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *National Healthcare Disparities Report* (Rockville: Agency for Healthcare Research and Quality, July 2003), 15, available at http://qualitytools.ahrq.gov/disparitiesreport/documents/Report%207.pdf, accessed February 26, 2004 [hereinafter *NHDR*]. The version of the *NHDR* that was released in December of 2003 was criticized as underestimating the problem of racial and ethnic disparities that were identified in the July 2003 version that was submitted to the Administration for clearance. U.S. House of Representatives Committee on Government, Minority Staff Special Investigations Unit, *A Case Study in Politics and Science: Changes to the NHDR* (January 2004), available at http://www.house.gov/reform/min/politicsandscience/pdfs/pdf_politics_and_science_disparities_rep.pdf, accessed February 24, 2004. The official version is now the July (not December) version.

3 For more information on health care issues concerning special populations, see, e.g., http://www.healthfinder.gov/justforyou, accessed February 16, 2004; http://surveillance.cancer.gov/disparities/, accessed March 6, 2004; http://wonder.cdc.gov/DATA2010, accessed March 17, 2004. See also Charlotte Schoenborn and others, *Health Behaviors of Adults, 1999-2001* (Hyattsville: National Center for Health Statistics, U.S. Department of Health and Human Services, 2004), available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_219.pdf, accessed March 17, 2004 [hereinafter Schoenborn]. The two most comprehensive reports on health disparities since the 2001 *Report Card* are *NHDR*, *supra* note 2 and Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington: The National Academies Press, 2002) [hereinafter *Unequal Treatment*], available at http://www.nap.edu (concluding that racial and ethnic minorities receive lower-quality health care than Whites, even when they have similar incomes, insurance coverage, and conditions).

4 For more information on the issue of the legal parameters and practices about data collection by race and ethnicity, see National Health Law Program, *Assessment of State Laws, Regulations and Practices Affecting the Collection and Reporting of Racial and Ethnic Data by Health Insurers and Managed Care Plans: Preliminary Findings: Phase 1* (study conducted October 2000 through May 2001), available at http://www.omhrc.gov/omh/sidebar/datastats13.htm#reports, accessed February 16, 2004; Ruth T. Perot and Mara Youdelman, *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices* (New York: Commonwealth Fund, Inc., 2001); U.S. Food and Drug Administration, *Draft Guidance: Collection of Race and Ethnicity Data in Clinical Trials*, available at http://www.fda.gov/cber/gdlns/racethclin.htm, accessed February 2, 2004.

5 See *NHDR, supra* note 2; *Unequal Treatment, supra* note 3. There is also evidence that increasing the racial and ethnic diversity among health care professionals will improve access to health care for racial and ethnic minorities. Institute of Medicine, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* (Washington: National Academies Press, 2004), available at http://www.nap.edu; Michael Late, "Many Americans Unaware of Racial and Ethnic Disparities, " *The Nation's Health* (November 2003), 6.

6 *NHDR, supra* note 2, at 153-161; Wilhelmina Leigh and Maren Jimenez, National Institutes of Health, *Women of Color Health Data Book* (Bethesda: National Institutes of Health, Office of the Director, undated), available at http://www4.od.nih.gov/orwh/wocEnglish2002.pdf, accessed March 5, 2004 [hereinafter *Women of Color Health Data Book*]; U.S. Department of Health and Human Services, Office on Women's Health, *The Health of Minority Women* (July 2003), available at http://www.4women.gov/owh/pub/minority/, accessed February 9, 2004 [hereinafter *Health of Minority Women*]; U.S. Department of Health and Human Services, Office on Women's Health, *National Centers of Excellence in Women's Health Second National Forum, Understanding Health Differences and Disparities in Women—Closing the Gap* (May 2003), available at http://www.4woman.gov/COE/forum.executivesummary.pdf, accessed February 24, 3004; Michele Casper and others, *Women and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality, Second Edition* (Morgantown: West Virginia University Office for Social Environment and Health Research, 2000), available at http://www.cdc.gov/cvh/maps/cvdatlas/atlas_womens/womens_download.htm, accessed March 19, 2004; *Journal of the American Medical Women's Association* 56 (Fall 2001) (issue dedicated to disparities in women's health); *American Journal of Public Health* 92 (April 2002) (collection of articles on women and health disparities); Shiriki Kumanyika and others, "Minority Women and Advocacy for Women's Health," *American Journal of Public Health* 91 (September 2001), 1383-1388; NARAL Pro-Choice America Foundation Proactive Policy Institute, *Breaking Barriers: A Policy Action Kit Promoting the Reproductive Health of Women of Color and Low-Income Women* (Washington: NARAL Pro-Choice America Foundation Proactive Policy Institute, 2003), available at http://www.naral.org/publications/breaking_barriers.cfm, accessed February 24, 2004.

7 For more information on Black women's health generally, see *Women of Color Health Data Book, supra* note 6, especially at 17-22; National Black Women's Health Project and others, *National Colloquium on Black Women's Health* (Washington: National Black Women's Health Project, 2003), available at http://www.BlackWomensHealth.ORG, accessed March 3, 2004 (National Black Women's Health Project was renamed Black Women's Health Imperative).

8 For more information about differences within the Black community, see *Women of Color Health Data Book, supra* note 6, at 17; University of Michigan, "Black Americans: U-M Study Documents Differences Within the Community" (January 22, 2004), available at http://www.umich.edu/news/index.html?Releases/2004/Jan04/r012204, accessed February 24, 2004 [hereinafter U-M Study]. For further information on cultural competence, see note 47 *infra*.

9 In the *Report Card's* education and poverty status indicators, women are considered Hispanic if they identify themselves as both Black and Hispanic. For more on this, see "Population of Females, by Race, by Age, and Total" Data Source note in the Methodology section.

10 *Women of Color Health Data Book, supra* note 6, at 93 (1998 data).

[11] Rachel Jones and others, "Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001," *Perspectives on Sexual and Reproductive Health* 34 (September/October 2002), 226-235) [hereinafter Jones]. There is evidence that declining abortion rates are due largely to improved contraceptive access. *Ibid.*

[12] American Cancer Society, *Cancer Facts & Figures 2004* (Atlanta: American Cancer Society, 2004), 26-29 [hereinafter *Cancer Facts 2004*] (for year 2000, adjusted to 2000 U.S. standard population, citing National Health Interview Survey, National Center for Health Statistics, percentage for Pap tests for women were as follows: Black 85.5 percent, non-Hispanic White 83.9, American Indian/Alaskan Native 78.4, Hispanic 77.9, and Asian American 68.2). Mammogram percentages were as follows: White non-Hispanic (72.1 percent); Black (68.2); Hispanic (62.6), Asian American (57.0), American Indian/Alaskan Native (52.0)).

[13] 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).

[14] 42 U.S.C. § 300k.

[15] *NHDR, supra* note 2, at 9. For a further discussion of this screening and treatment program, see National Women's Law Center and The Henry J. Kaiser Family Foundation, *Women's Access to Care: A State-Level Analysis of Key Health Policies* (Menlo Park: The Henry J. Kaiser Family Foundation, 2003), 63-65, available at http://www.nwlc.org/pdf/KaiserFinal.pdf [hereinafter *Women's Access to Care*].

[16] Eric Schneider and others, "Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care," *Journal of the American Medical Association* 287 (March 13, 2002), 1288-1294.

[17] *NHDR, supra* note 2, at 154.

[18] American Cancer Society, *Cancer Facts & Figures for African Americans 2003-2004* (Atlanta: American Cancer Society, 2003), 13 [hereinafter *Cancer Facts for African Americans*]; American Cancer Society, *Cancer Facts & Figures for Hispanics/Latinos 2003-2005* (Atlanta: American Cancer Society, 2003) [hereinafter *Cancer Facts for Hispanics/Latinos*], 8 (citing CDC study with 2001 data) (the percentages for women who reported that they did not engage in any leisure-time physical activity were as follows: non-Hispanic Black 38.8 percent; Hispanic 38.3; non-Hispanic White 24.9. Similarly, a greater percentage of Black non-Hispanic female high school students also did not engage in vigorous or moderate physical activity (16.9 percent) compared to non-Hispanic Whites (10.2 percent); Hispanics (13.0 percent)). For more on women exercising by ethnicity and race, see Schoenborn, *supra* note 3, at 40, 46, 49, 52.

[19] Sue Kimm and others, "Decline in Physical Activity in Black and White Girls During Adolescence," *New England Journal of Medicine* 347 (September 5, 2002), 709-715.

[20] Schoenborn, *supra* note 3, at 56, 62 (34.9 percent of non-Hispanic Black women were obese, compared to 25.5 percent of Hispanic women and 19.3 percent of non-Hispanic White women).

[21] National Women's Law Center and Oregon Health & Science University, *Women and Smoking: A National and State-by-State Report Card* (Washington: National Women's Law Center, 2003), 8-11, 17-18, 87, available at http://www.nwlc.org/pdf/Women&Smoking2003.pdf [hereinafter NWLC *Women and Smoking*]. For other information about smoking disparities among women of different races and ethnicities, see also *Cancer Facts for African Americans, supra* note 18, at 12; Denise Kandel and others, "Racial/Ethnic Differences in Cigarette Smoking Initiation and Progression to Daily Smoking: A Multilevel Analysis," *American Journal of Public Health* 94 (January 2004), 128-135; *Journal of Public Health* 94 (February 2004) (several articles on disparities and smoking); Elizabeth Barbeau and others, "Working Class Matters: Socioeconomic Disadvantage, Race/Ethnicity, Gender, and Smoking in NHIS 2000," 269-278); *NHDR, supra* note 2, at 79 (Table 1).

[22] Schoenborn, *supra* note 3, at 7-8 (for 1999-2001, Native Hawaiian or other Pacific Islander women (60.4 percent) and White women (60.4 percent) were considerably more likely to be current drinkers than were Black women (39.4 percent) and Asian women (30.3 percent); White women (4.1 percent) were four times as likely as Asian women (1.0 percent) to be heavier drinkers; non-Hispanic women (4.0 percent) were almost three times as likely as Hispanic women (1.4 percent) to be heavier drinkers; non-Hispanic White women (13.8 percent) were almost twice as likely as Hispanic women (7.0 percent) to have consumed five or more drinks in one day in the past year). In its status indicator on binge drinking, the *Report Card* defines binge drinking as five or more drinks consumed on one occasion during the past month. See "Binge Drinking" Data Source note in Chapter II, page 132.

[23] *NHDR, supra* note 2, at 155 (13 per 100,000 and 1 per 100,000 respectively).

[24] For this paragraph, the following rates for 1996 to 2000 from *Cancer Facts 2004, supra* note 12, at 23 are per 100,000 population, age-adjusted to the 2000 U.S. standard population. Death rates in women for all cancers combined are as follows: Black 198.6 per 100,000, White 166.9, American Indian/Alaskan Native 115.8, Hispanic 112.4, Asian/Pacific Islander 102.0. Death rates in women for breast cancer are: Black 35.9 per 100,000, White 27.2, Hispanic 17.9, American Indian/Alaskan Native 14.9, Asian/Pacific Islander 12.5. Death rates in women for colorectal cancer are: Black 24.6 per 100,000, White 17.5, American Indian/Alaskan Native 12.1, Hispanic 11.4, Asian/Pacific Islander 11.0. Death rates in women for cervical cancer are: Black 5.9 per 100,000, Hispanic 3.7, Asian/Pacific Islander and American Indian/Alaskan Native both 2.9, and White 2.7. Death rates in women for lung cancer are: White 41.5 per 100,000, Black 40.0, American Indian/Alaskan Native 26.2, Asian/Pacific Islander 19.1, Hispanic 15.1.

[25] *NHDR, supra* note 2, at 155.

[26] Centers for Disease Control and Prevention, "HIV/AIDS Among African Americans," undated, available at http://www.cdc.gov/hiv/pubs/Facts/afam.htm.

[27] *Ibid.*

[28] For this paragraph, the following rates for 1996 to 2000 are from *Cancer Facts 2004, supra* note 12, at 23 and are per 100,000 population, age-adjusted to the 2000 U.S. standard population. The incidence rates in women for all cancers combined are: White 431.8, Black 406.3, Hispanic 312.2, Asian/Pacific Islander 306.9, Native American 229.2. The lung cancer incidence rates for women are: Black 54.8 per 100,000, White 51.9, Asian/Pacific Islander 28.4, Hispanic 24.4, Native American 23.4. The colorectal cancer incidence rates for women are: Black 56.2 per 100,000, White 46.2, Asian/Pacific Islander 38.8, Hispanic 32.9, Native American 32.6. The breast cancer incidence rates for women are: White 140.8 per 100,000, Black 121.7, Asian American/Pacific Islander 97.2, Hispanic 89.8, and Native American 58.0. The cervical cancer incidence rates for women are: Hispanic 16.8 per 100,000, Black 12.4, Asian/Pacific Islander 10.2, White 9.2, Native American 6.9.

[29] Cathy Bradley and others, "Race, Socioeconomic Status, and Breast Cancer Treatment and Survival," *Journal of the National Cancer Institute* 94 (April 3, 2002), 490-496; Otis Brawley, "Disaggregating the Effects of Race and Poverty on Breast Cancer Outcomes," *Journal of the National Cancer Institute* 94 (April 3, 2002), 471-473; Richard Roetzheim and others, "Effects of Health Insurance and Race on Early Detection of Cancer," *Journal of the National Cancer Institute* 91 (August 18, 1999), 1409-1415.

[30] Jill Barnholtz-Sloan and others, "Ethnic Differences in Survival among Women with Ovarian Carcinoma," *Cancer* 94 (March 15, 2002), 1886-1891.

[31] See Kauther Umar, "Maternal Mortality: African Americans Remain at Higher Risk," *Closing the Gap* (January/February 2004), 1 (CDC study examining the years 1991 to 1999 found that, over this period, Black women died three times more often from pregnancy-related complications than non-Hispanic White women); *NHDR, supra* note 2, at 155 (women of racial and ethnic minorities are more likely to die from obstetrical complications).

[32] U-M Study, *supra* note 8, at Table 2 (Lifetime Physical Health/Chronic Conditions); see also Ashish Jha and others, "Differences in Medical Care and Disease Outcomes Among Black and White Women with Heart Disease," *Circulation* 108 (September 2, 2003), 1089-1094 [hereinafter Jha]; Julie Piotrowski, "Heartening Outcomes," *Modern Healthcare* (October 27, 2003), 20, 26 [hereinafter "Heartening Outcomes"].

[33] Jha, *supra* note 32.

[34] *Ibid.*; "Heartening Outcomes," *supra* note 32.

[35] Dorothy Dunlop and others, "Racial/Ethnic Differences in Rates of Depression Among Preretirement Adults," *American Journal of Public Health* 93 (November 2003), 1945-1952; Ann O'Malley, "Primary Care Attributes and Care for Depression Among Low-Income African American Women," *American Journal of Public Health* 93 (August 2003), 1328-1334; Shauna Curphey, "Black Women Mental-Health Needs Unmet," *Women's eNews,* June 24, 2003, available at http://www.womensenews.com/article.cfm/dvn/aid/1392, accessed March 19, 2004. For information about mental health issues among African Americans generally, see U.S. Department of Health and Human Services, *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General* (Rockville: U.S. Department of Health and Human Services, 2001), 51-69 (available at http://www.surgeongeneral.gov/library/mentalhealth/cre/, accessed February 26, 2004 [hereinafter *Mental Health Race and Ethnicity*]; A.R. Bhuiyan and others, "Differences in Body Shape Representations among Young Adults from a Biracial (Black-White), Semirural Community: The Bogalusa Heart Study," *American Journal of Epidemiology* 158 (2003), 792-797; Sheila Parker and others, "Body Image and Weight Concerns among African Americans and White Adolescent Females: Differences that Make a Difference," *Human Organization* 54 (Summer 1995), 103-114; "Minority Women's Health Concerns: Psychiatric Disorders," in *The Health of Minority Women, supra* note 6.

[36] *NHDR, supra* note 2, at 160 (citing 2001 data that 15 percent of White women, nine percent Black women, 16 percent non-Hispanic White and seven percent Hispanics had mental health treatment or counseling in the past year).

[37] U-M Study, *supra* note 8.

[38] *Women of Color Health Data Book, supra* note 6, at 20-21.

[39] *Ibid.* 19-21; Vernellia R. Randall, "Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African Americans," in *Health Matrix* 3 (1993), 127; N. Murrell, "Racism and Health Care Access: A Dialogue with Childbearing Women," *Health Care for Women International* 17 (London: Taylor & Francis Group, 1996), 149-159, both articles as described in Vernellia R. Randall, *The Current Status of Minorities' Access to Health Care: Annotated Bibliography* (Spring 1997), available at http://academic.udayton.edu/health/03access/97unknow.htm, accessed February 24, 2004.

[40] For more information about Hispanic women's health generally, see *Women of Color Health Data Book, supra* note 6, especially 12-17. For more information on Hispanic health generally, see Michelle Doty, The Commonwealth Fund, *Insurance, Access, and Quality of Care Among Hispanic Populations: 2003 Chartpack*, available at http://www.cmwf.org/programs/minority/doty_hispanicchartpack_684.pdf, accessed February 16, 2004.

[41] Council of Economic Advisers for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington: Government Printing Office, September 1998), 6, available at http://w3.access.gpo.gov/eop/ca/pdfs/ca.pdf, accessed February 25, 2004 (when compared against Black non-Hispanic, Asian, and American Indian) [hereinafter Council of Economic Advisers].

[42] *Women of Color Health Data Book, supra* note 6, at 12 (citing Census 2000 data); "Gaps in Preventive Care between African Americans and Whites Close, While Hispanics Still Lag Far Behind," Center for Studying Health System Change (January 16, 2001), available at http://www.hschange.org/CONTENT/288/?words=hispanics+preventive+health+services accessed February 24, 2004.

[43] Hispanic women can be of any race, but most of the data report information about Hispanics in their own category; for example, even though there are White Hispanics and Black Hispanics, data are often reported as White non-Hispanic, Black non-Hispanic, and Hispanic. When Hispanic data are not separated by race, people who describe themselves as both Black and Hispanic are sometimes considered Hispanic (for example in the *Report Card's* poverty and education status indicators).

[44] For more on Hispanics and health insurance, see American College of Physicians and American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick: Latino Community at Great Risk* (Philadelphia: American College of Physicians and American Society of Internal Medicine, 2000), 6, available at http://www.acponline.org/uninsured/lack-contents2.htm, accessed March 3, 2004.

[45] Richard Roetzheim and others, "Effects of Health Insurance and Race on Early Detection of Cancer," *Journal of the National Cancer Institute* 91 (August 18, 1999), 1409-1415.

[46] Jones, *supra* note 11.

[47] For more on Hispanics and linguistic and cultural barriers, see National Alliance for Hispanic Health, *Quality Health Services for Hispanics: The Cultural Competency Component* (Rockville: U.S. Department of Health and Human Services, 2001). For more information on linguistic, cultural, and communication barriers generally, see Chapter III, page 168; Institute of Medicine, *Speaking of Health: Assessing Health Communication Strategies for Diverse Populations* (Washington: National Academies Press, 2004), available at http://www.nap.edu; Jane Perkins, *Ensuring Linguistic Access in Health Care Settings: An Overview of Legal Rights and Responsibilities* (Menlo Park: The Henry J. Kaiser Family Foundation, 2003), available at http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22093 (February 16, 2004); *Women of Color Health Data Book*, supra note 6; Council of Economic Advisers, supra note 41, at 60-61, 67; Mara Youdelman and Jane Perkins, *Providing Language Interpretation Services in Health Care Settings: Examples from the Field* (New York: The Commonwealth Fund, 2002), available at http://www.healthlaw.org/pubs/200205.cmwfrelease.html, accessed February 24, 2004; Leighton Ku and Timothy Waidmann, *How Race/Ethnicity, Immigration Status and Language Affect Health Insurance, Access to Care and Quality Among the Low-Income Population* (Menlo Park: The Henry J. Kaiser Family Foundation, 2003), available at http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22103, accessed March 19, 2004; Center on Aging, Georgetown University, "Cultural Competence in Health Care: Is it Important for People with Chronic Conditions," Issue Brief No. 5 (February 2004), available at http://ihcrp.georgetown.edu/agingsociety/pubhtml/cultural/cultural.html, accessed March 17, 2004.

[48] For a further discussion of some of the changes concerning the U.S. Census and accurate counting of ethnic and minority groups, see National Women's Law Center and others, *Making the Grade on Women's Health: A National and State-by-State Report Card* (Washington: National Women's Law Center, 2001), 199-200 and accompanying text, available at http://www.nwlc.org/display.cfm?section=health. See also "Population of Females by Race, by Age, and Total" Data Source note in Methodology section of this *Report Card.*

[49] *Women of Color Health Data Book, supra* note 6, at 16.

50 *Cancer Facts 2004, supra* note 12, at 28-29 (for year 2000, adjusted to 2000 U.S. standard population, cervical cancer screening rates for women are: non-Hispanic White 83.9 percent, non-Hispanic Black 85.5, non-Hispanic American Indian/Alaskan Native 78.4, Hispanic 77.9, Asian American 68.2).

51 *Cancer Facts 2004, supra* note 12, at 26-28. The National Association of Community Health Centers has launched a program to encourage more Spanish-speaking women to get early breast and cervical cancer screening. National Association of Community Health Centers, "Latina Breast & Cervical Cancer Initiative," http://www.nachc.com/programs/latina.asp, accessed February 15, 2004.

52 *NHDR, supra* note 2, at 154 (citing National Health Information Survey 2000).

53 *Cancer Facts for African Americans, supra* note 18, at 13 (38.3 percent of Hispanics, 38.8 percent of non-Hispanic Blacks, and 24.9 percent of non-Hispanic Whites did not engage in leisure-time physical activity); *Cancer Facts for Hispanics/Latinos, supra* note 18, at 8 (citing CDC study for activity in 2001) (a greater percentage of Black non-Hispanic female high school students also did not engage in vigorous or moderate physical activity (16.9 percent) compared to non-Hispanic Whites (10.2 percent) and Hispanics (13.0 percent)). For more on women exercising by ethnicity and race, see Schoenborn, *supra* note 3, at 40, 46, 49, 52.

54 "Minority Women's Health Status: Risk Factors for Disease," in *The Health of Minority Women, supra* note 6.

55 Schoenborn, *supra* note 3, at 56, 62.

56 For more information on Hispanic women and smoking, see note 21 *supra; Cancer Facts for Hispanics/Latinos, supra* note 18, at 6-8.

57 Schoenborn, *supra* note 3, at 7-8.

58 Ashley Hedeen and Emily White, "Breast Cancer Size and Stage in Hispanic American Women, by Birthplace 1992-1995," *American Journal of Public Health* 91 (2001), 122-125.

59 *Cancer Facts 2004, supra* note 12, at 23 (breast cancer incidence rates for women: White 140.8 per 100,000, Black 121.7, Asian/Pacific Islander 97.2, Hispanic 89.8, and Native American 58.0).

60 *Cancer Facts 2004, supra* note 12, at 23 (cervical cancer death rates for women: Black 5.9, Hispanic 3.7, Asian/Pacific Islander and American Indian/Alaskan Native both 2.9, and White 2.7).

61 For more information about Hispanics and mental health generally, see *Mental Health Race and Ethnicity, supra* note 35, at 127-155.

62 "Minority Women's Health Concerns: Psychiatric Disorders," in *The Health of Minority Women, supra* note 6.

63 *NHDR, supra* note 2, at 160 (citing 2001 data that 15 percent of White women had mental health treatment or counseling in the past year, compared to nine percent of Black women, 16 percent of non-Hispanic White women and seven percent of Hispanic women).

64 *Cancer Facts 2004, supra* note 12, at 23 (cervical cancer incidence rates for women: Hispanic 16.8 per 100,000, Black 12.4, Asian/Pacific Islander 10.2, White 9.2, American Indian/Alaskan Native 6.9).

65 L.R. Armstrong and others, "Invasive Cervical Cancer among Hispanic and Non-Hispanic Women—United States 1992-1999," *Morbidity and Mortality Weekly Report* 51 (November 29, 2002), 1067-1070 (for women age 30 and older, incidence of cervical cancer for Hispanic women was 16.9 cases per 100,000 and 8.9 cases per 100,000 non-Hispanic women). See also *Cancer Facts for Hispanics/Latinos, supra* note 18, at 5 (noting also the relationship between human papilloma virus (HPV) and cervical cancer, as well as the high incidence of HPV in women in the United States who were born in Mexico).

66 In 2002, for workers age 15 and older, women working full-time, full-year had median earnings of $30,203; men earned $39,429; White women earned $31,402; Black women earned $26,882; Hispanic women earned $21,910. U.S. Census Bureau, "Detailed Income Tabulations—Person," Table PINC-05 (October 3, 2003), available at http://ferret.bls.census.gov/macro/032003/perinc/toc.htm, accessed March 3, 2004.

67 *Women of Color Health Data Book, supra* note 6, at 14.

68 *Ibid.*

69 *Ibid.*, 15-16; Mollyann Brodie and others, *2002 National Survey of Latinos* (Menlo Park: The Henry J. Kaiser Family Foundation, 2002), available at http://www.kff.org/kaiserpolls/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14043, accessed February 16, 2004.

70 For more information about women who are Asian, Native Hawaiian, and other Pacific Islanders, see *Women of Color Health Data Book, supra* note 6, especially at 7-12, 22-29; National Asian Women's Health Organization (NAWHO), http://www.nawho.org. For information on Asian health generally, see National Institutes of Health's National Library of Medicine, *Asian American Health*, available at http://asianamericanhealth.nlm.nih.gov, accessed February 16, 2004; Chandak Ghosh, "*Healthy People 2010* and Asian Americans/Pacific Islanders: Defining a Baseline of Information," *American Journal of Public Health* 93 (December 2003), 2093-2098 (noting also that several studies were based solely on studying Japanese American men).

71 *Women of Color Health Data Book, supra* note 6, at 23 (citing Census 2000).

72 *Ibid.*, 7.

73 For example, the Cantonese translation for "cancer" is the word "nham," which loosely translates into English as "growth" but is not mentioned as a disease in texts on Chinese medicine. *Women of Color Health Data Book, supra* note 6, at 29. For more information about linguistic access and cultural competence in health care generally, see note 47 *supra.*

74 *Women of Color Health Data Book, supra* note 6, at 26.

75 *Ibid.*, 28.

76 *NHDR, supra* note 2, at 58-59, 155 (86 percent of White women had this prenatal care, compared to 69 percent for Native Hawaiians or other Pacific Islanders). In one study looking at prenatal care use among selected Asian American groups (Chinese, Korean, Japanese, and Vietnamese), Korean Americans and Vietnamese Americans had the lowest levels of prenatal care use. Stella Yu and others, "Selected Prenatal Care Use Among Selected Asian American Groups," *American Journal of Public Health* 91 (November 2001), 1865-1868.

77 Jones, *supra* note 11, at 228 (Table 1).

78 According to a 1997 study published by the National Asian Women's Health Organization, almost 50 percent of the participants had not seen a health care provider within the past year for reproductive health services, and 25 percent had never seen such a provider. National Asian Women's Health Organization, *Report of Activities 1997-1999* (San Francisco: National Asian Women's Health Organization, 1997), 9-10.

79 *Cancer Facts 2004, supra* note 12, at 28-29 (for year 2000, adjusted to 2000 U.S. standard population, citing National Health Interview Survey) (percent of women reporting a Pap smear: Asian American 68.2 percent, non-Hispanic White 83.9, non-Hispanic Black 85.5, Hispanic 77.9, and non-Hispanic Native American 78.4). See also Kauthar Umar, "Breaking Cultural Barriers: Cervical Cancer in Asian American and Pacific Islander Women," *Closing the Gap* (January/February 2004), 11 [hereinafter "Breaking Cultural Barriers"]. For earlier data, see 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), 97 [hereinafter Hahn].

[80] *Cancer Facts 2004, supra* note 12, at 26-28 (for year 2000, adjusted to 2000 U.S. standard population, citing National Health Interview Survey) (for women age 40 and older, percent reporting a mammogram: Asian American 57.0 percent, non-Hispanic White 72.1, non-Hispanic Black 68.2, Hispanic 62.6, non-Hispanic Native American 52.0).

[81] Hahn, *supra* note 79, at 98. See also "Breaking Cultural Barriers," *supra* note 79 (in 2000, the following reported receiving a Pap test, within the past three years (age adjusted, age 18 and older): Black non-Hispanic 84 percent, White non-Hispanic 83 percent, Hispanic/Latina 77 percent, American Indian/Alaskan Native 76 percent; Asian 66 percent).

[82] Marisa Urgo, "New Obesity Guidelines: Minority Women at Risk," in *Closing the Gap* (June/July 1998), 6. Although Asian American/Pacific Islander women in general have the lowest rates of overweight (9.6 percent), Native Hawaiian and American Samoan women (63 percent and 66 percent, respectively) have the highest occurrence of obesity of any other major racial or ethnic group or specific population within those major groups. *Women of Color Health Data Book, supra* note 6, at 9-10. The *Report Card* in its health status indicator uses the *Healthy People 2010* benchmark and definition for obese. See "Obese" Data Source note in Chapter II, page 129.

[83] "Minority Women's Health Status: Risk Factors for Disease," in *The Health of Minority Women, supra* note 6. For additional information on Asian women and smoking, see note 21 *supra*.

[84] Schoenborn, *supra* note 3, at 7-8 (for 1999-2001, Native Hawaiian or other Pacific Islander women (60.4 percent) and White women (60.4 percent) were considerably more likely to be current drinkers than Black women (39.4 percent) and Asian women (30.3); White women (4.1 percent) were four times as likely as Asian women (1.0 percent) to be heavier drinkers; non-Hispanic women (4.0 percent) were almost three times as likely as Hispanic women (1.4 percent) to be heavier drinkers; non-Hispanic White women (13.8 percent) were almost twice as likely as Hispanic women (7.0 percent) to have consumed five or more drinks in one day in the past year. In its status indicator on binge drinking, the *Report Card* defines binge drinking as five or more drinks consumed on one occasion during the past month. See "Binge Drinking" Data Source note in Chapter II, page 132.

[85] *Cancer Facts 2004, supra* note 12, at 23 (all data in this paragraph are from 1996 to 2000; rates in women per 100,000 population, age-adjusted to the 2000 U.S. standard population). The death rates for women for all cancers combined are: Black 198.6 per 100,000, White 166.9, American Indian/Alaskan Native 115.8, Hispanic 112.4, Asian/Pacific Islander 102.0. The death rates for women for breast cancer are: Black 35.9 per 100,000, White 27.2, Hispanic 17.9, Native American 14.9, and Asian/Pacific Islander 12.5. The death rates for women for colorectal cancer are: Black 24.6 per 100,000, White 17.5, Native American 12.1, Hispanic 11.4, Asian American/Pacific Islander 11.0. Lung cancer death rates for women are: White 41.5 per 100,000, Black 40.0, Native American 26.2, Asian American/Pacific Islander 19.1, Hispanic 15.1. Cervical cancer death rates for women are: Black 5.9 per 100,000, Hispanic 3.7, Asian/Pacific Islander and American Indian/Alaskan Native both 2.9, and White 2.7.

[86] *Cancer Facts 2004, supra* note 12, at 22; "Breaking Cultural Barriers," *supra* note 79, at, 10-11.

[87] National Cancer Institute, "Ovary" in *Racial/Ethnic Patterns of Cancer in the United States, 1988-1992* (1996), available at http://seer.cancer.gov/publications/ethnicity/, accessed March 6, 2004; National Cancer Institute, "Cervical Cancer and Asian and Pacific Islander Populations: Vietnamese American Women," available at http://www.cdc.gov/cancer/nbccedp/cc-strategies/vietnamese.htm, accessed March 6, 2004.

[88] *Women of Color Health Data Book, supra* note 6, at 25.

[89] For more on Native American women generally, see *Women of Color Health Data Book, supra* note 6, at 3-7; Charon Asetoyer and others, eds., American Women's Health Education Resource Center, *Indigenous Women's Health Book, Within the Sacred Circle* (Lake Andes: Indigenous Women's Press, 2003); Kati Schindler and others, *Indigenous Women's Reproductive Rights: The Indian Health Service and Its Inconsistent Application of the Hyde Amendment* (Lake Andes: Native American Women's Health and Education Resource Center, 2002); The Henry J. Kaiser Family Foundation, "American Indians and Alaskan Natives: Health Coverage and Access to Care" February 2004, available at http://www.kff.org/minorityhealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=31131, accessed March 5, 2004; *Morbidity and Mortality Weekly Report* 52 (August 1, 2003) (issue addresses health disparities experienced by American Indians and Alaskan Natives, including analyses by sex); Stephen Zuckerman and others, "Health Service Access, Use, and Insurance Coverage Among American Indians/Alaskan Natives and Whites: What Role Does the Indian Health Service Play," *American Journal of Public Health* 94 (January 2004), 53-59.

[90] *Women of Color Health Data Book, supra* note 6, at 3.

[91] *Ibid.*

[92] *Ibid.*, 3-4.

[93] *Ibid.*, 4.

[94] *NHDR, supra* note 2, at 58-59, 155 (Native Americans have significantly lower rates (69 percent) of prenatal care during the first trimester than all other groups analyzed).

[95] *Women of Color Health Data Book, supra* note 6, at 6. For more on language and communications issues generally, see note 47 *supra*.

[96] *Cancer Facts 2004, supra* note 12, at 26-29 (for year 2000, adjusted to 2000 U.S. standard population, citing National Health Interview Survey) (Pap percentages are: non-Hispanic Black 85.5 percent, non-Hispanic White 83.9, non-Hispanic Native American 78.4, Hispanic 77.9, Asian American 68.2; mammogram percentages are: non-Hispanic White 72.1 percent, non-Hispanic Black 68.2, Hispanic 62.6, Asian American 57.0, non-Hispanic Native American 52.0).

[97] *Women of Color Health Data Book, supra* note 6, at 5 (diabetes rate: 9.7 per 100,000).

[98] See note 21 *supra* for smoking information.

[99] *Women of Color Health Data Book, supra* note 6, at 6.

[100] See also U.S. Department of Health and Human Services, Indian Health Service, "Violence Against Native Women" (resource list), available at http://www.ihs.gov/MedicalPrograms/MCH/W/DV08.cfm#top, accessed February 19, 2004.

[101] For a discussion of mental health issues among Native Americans and Alaskan Natives (not limited to women), see *Mental Health Race and Ethnicity, supra* note 35, at 79-97.

[102] *Women of Color Health Data Book, supra* note 6, at 4-5.

[103] *Ibid.*, 5.

[104] Unless otherwise indicated, "immigrant" is used synonymously in this chapter with "foreign-born" and "non-citizen," and refers to people born in another country who were not U.S. citizens at birth. For a discussion of definitions, see Dianne Schmidley, U.S. Census Bureau, "The Foreign-Born Population in the United States: March 2002," *Current Population Reports* (February 2003), 1, available at http://www.census.gov/prod/2003pubs/p20-539.pdf, accessed February 24, 2004 [hereinafter Schmidley 2003]. For further information on women immigrants, and immigrants generally, see Philippa Strum and Danielle Tarantolo (eds.), *Women Immigrants in the United States* (Washington:

Woodrow Wilson International Center for Scholars, 2003), available at http://wwics.si.edu/topics/pubs/womenimm_rpt.pdf; accessed March 19, 2004; Diane Schmidley, U.S. Census Bureau, *Profile of the Foreign-Born Population in the United States: 2000* (Washington: U.S. Government Printing Office, 2001), available at http://www.census.gov/prod/2002pubs/p23-206.pdf, accessed February 24, 2004; Kaiser Commission on Medicaid and the Uninsured, "Immigrants' Health Care Coverage and Access," August 2003, available at http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22152 [hereinafter "Immigrants' Health Care Coverage"]; Human Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Women's Health USA 2003* (Vienna: U.S. Health Resources and Services Administration (HRSA), 2003), 58 (2001 data), available at http://mchb.hrsa.gov/data/women03.htm, accessed February 26, 2004 [hereinafter *Women's Health USA 2003*].

105 U.S. Census Bureau, Foreign-Born Population of the United States Current Population – March 2002 Detailed Tables (PPL-162), Table 1.1 (March 2002 Current Population Survey) (population for 2002 of females of all ages), available at http://www.census.gov/population/www/socdemo/foreign/ppl-162.html#cit (list of tables), http://www.census.gov/population/socdemo/foreign/ppl-162/tab01-01.pdf (Table 1.1).

106 Schmidley 2003, *supra* note 104, at 1-2 (data for 2002; 14 percent born in Europe; statistics apply to both men and women).

107 "Immigrants' Health Care Coverage," *supra* note 104 (citing Census 2000 data).

108 Gopal K. Singh and Mohammad Siahpush, "All-Cause and Cause-Specific Mortality of Immigrants and Native Born in the United States," *American Journal of Public Health* 91 (March 2001), 392-399 (using data from National Longitudinal Mortality Study 1979-1989) [hereinafter Singh].

109 *Women's Health USA 2003, supra* note 104, at 127 (for women age 18 and older in 2001, 9.4 percent of U.S.-born citizens had no usual source of care (defined as not having a place they usually go to when they are sick), compared to 11.2 percent of naturalized citizens (people not born in the United States, but holding U.S. citizenship) and 18.9 percent non-citizens; 10.3 percent of U.S.-born citizens had no health insurance, compared to 13.5 percent of naturalized citizens and 41.3 percent of non-citizens).

110 "Immigrants' Health Care Coverage," *supra* note 104, at Figure 3 (in 2001, 57 percent of non-citizen, low-income women, compared with 28 percent of low-income citizens—men and women included) were uninsured; 16 percent of low-income non-citizen women had Medicaid/other public insurance, compared to 34 percent citizens (men and women); 60 percent of men and women non-citizens were uninsured and 14 percent of men and women non-citizens had Medicaid/other public insurance); Schmidley 2003, *supra* note 104.

111 "Immigrants' Health Care Coverage," *supra* note 104 (19 percent of low-income non-citizens received Medicaid in 1995, compared to 13 percent in 2001; uninsured rates during that period increased from 54 percent to 60 percent).

112 See The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), 42 U.S.C. Ch. 7, Subch. IV, Pt. A.; "Immigrants' Health Care Coverage," *supra* note 104. Qualified immigrants (those who entered the United States before August 22, 1996) retained eligibility for benefits, except in the case of food stamps. For those legal immigrants who entered after that date, eligibility for most depends on immigration status (generally, legal immigrants either need to be in the country for five years, or obtain citizenship to become eligible). Shawn Fremstad, "Immigrants and Welfare Reauthorization," February 4, 2002, 2, available at http://www.cbpp.org/1-22-02tanf4.htm, accessed March 24, 2004. In 2002, the federal government began allowing states to use federal State Children's Health Insurance Program (SCHIP) money to cover prenatal care by expanding the definition of "child" to include a fetus (i.e., a child is now defined as "an individual under the age of 19 including the period from conception to birth"). *Federal Register* 67 (October 2, 2002), 61956; 42 C.F.R. § 457.10(3). This rule change allows the unborn children of undocumented immigrant women access to SCHIP, thereby bringing more women into the program. However, as of March 2004, those few states that have adopted the new regulation were already covering these women's prenatal care with state funds. For a further discussion about the implications of the SCHIP regulation on women's health, see National Women's Law Center, "Update on Implementation of 'Unborn Child' SCHIP Regulations," February 2004, available at http://www.nwlc.org/pdf/SCHIPUpdateFeb2004logo.pdf

113 Kathleen A. Maloy and others, *Effect of the 1996 Welfare and Immigration Reform Laws on Immigrants' Ability and Willingness to Access Medicaid and Health Care Services* (Washington: Center for Health Services Research and Policy, May 2000 Synthesis Report), 32-35, available at http://www.gwu.edu/~chsrp/pdf/synth.pdf, accessed March 19, 2004.

114 *Ibid.*, 32-35.

115 For more information on the impact of language and cultural differences in health care generally, see note 47 *supra*.

116 American Public Health Association, "Recommendations for Further Research," *Understanding the Health Culture of Recent Immigrants to the United States: A Cross-Cultural Maternal Health Information Catalog*, undated, available at http://www.apha.org/ppp/red/furtherresearch.htm, accessed February 24, 2004.

117 "Immigrant Women's Health," *Journal of the American Medical Association* 283 (2000), 2451 (reviewing Elizabeth J. Kramer and others, *Immigrant Women's Health: Problems and Solutions* (San Francisco: Jossey-Bass Publishers, 1999)).

118 *Ibid.*

119 Singh, *supra* note 108, at 396 (source for all information in the text paragraph).

120 Schmidley 2003, *supra* note 104, at 5-7 (source for all information in the text paragraph).

121 For more information about the health of lesbians generally, see Gay and Lesbian Medical Association (GLMA) and others, *Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health* (San Francisco: GLMA, 2001), available at http://www.glma.org/policy/hp2010/index.shtml, accessed February 24, 2004; *American Journal of Public Health* 91 (June 2001) (series of articles on lesbian, gay, bisexual and transgender issues). For special issues related to African American lesbians, see The Mautner Project, http://www.mautnerproject.org. For Latina lesbian issues, see LLEGO, the National Latina/o Lesbian, Gay, Bisexual, and Transgender Organization, http://www.llego.org, accessed February 24, 2004.

122 See national report card in Chapter I and Demographic Data Sources in Methodology section of this *Report Card*; Marj Plumb, "Undercounts and Overstatements: Will the IOM Report on Lesbian Health Improve Research," *American Journal of Public Health* 91 (June 2001), 873-875.

123 Institute of Medicine, *Lesbian Health: Current Assessment and Directions for the Future – Executive Summary* (Washington: National Academy Press, 1999) [hereinafter IOM *Lesbian Health*]; Office of Women's Health, U.S. Department of Health and Human Services and others, *Scientific Workshop on Lesbian Health: Steps for Implementing the IOM Report*, undated, iv-viii, available at http://www.glma.org/policy/swlh_report.pdf, accessed February 18, 2004; Judith Bradford and others, "Improving the Accuracy of Identifying Lesbians for Telephone Surveys About Health," *Women's Health Issues* 11 (March/April 2001), 126-137.

[124] Allison L. Diamant and others, "Health Behaviors, Health Status, and Access to and Use of Health Care," *Archives of Family Medicine* 9 (2000), 1050 [hereinafter Diamant].

[125] Katherine A. O'Hanlan, Gay and Lesbian Medical Association, "Ten Things Lesbians Should Discuss with Their Health Care Providers," July 17, 2002,available at http://www.glma.org/news/releases/n02071710lesbianthings.html, accessed February 18, 2004 [hereinafter O'Hanlan].

[126] For example, in 2003, when the U.S. Department of Health and Human Services released a comprehensive statistical report on women's health, *Women's Health USA 2003, supra* note 104, there was no mention of lesbians. As of March 2004, the discussion of lesbian health on the federal Office on Women's Health website had not been updated since 1998. See Office on Women's Health, U.S. Department of Health and Human Services, "Lesbian Health," 1998, available at http://www.4women.gov/faq/Lesbian.htm?src=ng, accessed March 5, 2004. For more information about governmental policies affecting lesbians, see Human Rights Campaign, http://www.hrc.org.

[127] Diamant, *supra* note 124. In 1998, the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services published *Healthy People 2010 Objectives, Draft for Public Comment* (Washington: U.S. Department of Health and Human Services, 1998), text and comments available at http://www.health.gov/HPComments/2010Draft/object.htm, accessed February 25, 2004. One advocacy group noted that this draft report of the goals and objectives of *Healthy People 2010*, the nation's health "blueprint," was virtually silent on issues of lesbian health, and urged the project to incorporate the findings and recommendations made by the Institute of Medicine, discussed above. Human Rights Campaign, Press Release, "Federal Blueprint Healthy People 2010 Overlooks Gay and Lesbian Americans, HRC Asserts," January 27, 1999.

[128] Laura Dean and others, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association* 4 (2000), 106. [hereinafter Dean]; The Gay, Lesbian, Bisexual and Transgender Health Access Project, *Health Concerns of the Gay, Lesbian, Bisexual and Transgender Community*, Preface to the 2nd Edition (Boston: The Medical Foundation, 1997) [hereinafter *Health Concerns*].

[129] Susan Cochran and others, "Cancer-Related Risk Indicators and Preventive Screening Behaviors Among Lesbians and Bisexual Women," *American Journal of Public Health* 91 (April 2001), 591-597.

[130] For more information about the implications of civil unions, domestic partnership, and same-sex marriage issues generally, see Human Rights Campaign, http://www.hrc.org. For a description of state and local governments, as well as private companies, that offer domestic partner benefits, see Human Right Campaign, "Domestic Partner Benefits," available at http://www.hrc.org/Template.cfm?Section=The_Issues&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=26&ContentID=13399, accessed March 5, 2004.

[131] For updated information on state laws on health-related benefits for gays and lesbians, see Human Rights Campaign, "What's Happening in Your State & in Your Community," available at http://www.hrc.org/Template.cfm?Section=Your_Community&Template=/ContentManagement/ContentDisplay.cfm&ContentID=8471, accessed February 27, 2004. For more information on this issue, see also Center for Policy Alternatives, "Civil Marriage Equality: 2004 Policy Toolkit," available at http://www.stateaction.org/issues/civilmarriage/index.cfm. Vermont's civil unions law requires equal treatment of spouses and couples in a civil union, including in the writing of insurance policies. Vt. Stat. Ann. tit. 15, ch. 23. Maine just requires that insurers *offer* health insurance on the same basis, but does not require employers or others to buy the coverage. Me. Rev. Stat. tit. 24, §2319-A; tit. 24A, §§ 2741-A, 2832-A, 4249. In *Goodridge v. Department of Public Health*, slip op. No. 08860 (Mass. Nov. 18, 2003), Massachusetts' highest court held that it is unconstitutional (under the Massachusetts state constitution) to not issue marriage licenses to same-sex couples. Thus, unless there is a change in the Massachusetts state constitution, same-sex couples married in Massachusetts after mid-May 2004 will be legal spouses and treated the same as different-sex spouses for insurance purposes.

[132] IOM *Lesbian Health, supra* note 123. "Cultural competency"—a common notion when dealing with other patients across racial, ethnic and linguistic lines—is crucial to increase access and appropriate services. The Gay and Lesbian Medical Association's Physician Referral Program links lesbians with providers who express a commitment to addressing their unique health needs. Gay and Lesbian Medical Association, "Physician Referral Program," undated, available at http://www.glma.org/programs/prp/index.html, accessed February 24, 2004.

[133] Mary Ann van Dam and others, "Lesbian Disclosure to Health Care Providers and Delay of Care," *Journal of Gay and Lesbian Medical Association* 5 (2001), 11-19 [hereinafter van Dam]; Dean, *supra* note 128; The Mautner Project, "Removing the Barriers to Accessing Care for Lesbians," undated, available at http://www.mautnerproject.org/barriers.html, accessed February 24, 2004.

[134] Dean, *supra* note 128, at 108.

[135] NWLC *Women and Smoking, supra* note 21, at 18 (citing other sources); Dean, *supra* note 128, at 106-107; Deborah Aaron and others, "Behavioral Risk Factors for Disease and Preventive Health Practices Among Lesbians," *American Journal of Public Health* 91 (June 2001), 972-979; Elisabeth Gruskin and others, "Patterns of Cigarette Smoking and Alcohol Use among Lesbians and Bisexual Women Enrolled in a Large Health Maintenance Organization," *American Journal of Public Health* 91 (June 2001), 976-969; Susan Cochran and others, "Cancer-Related Risk Indicators and Preventive Screening Behaviors Among Lesbians and Bisexual Women," *American Journal of Public Health* 91 (April 2001), 591-597.

[136] Diamant, *supra* note 124, at 1045.

[137] Morten Frish and others, "Cancer in a Population-based Cohort of Men and Women in Registered Homosexual Partnerships," *American Journal of Epidemiology* 157 (November 2002), 966-972 (Danish study showing similar breast and cervical cancer rates among registered same-sex partners and married heterosexual women); *American Cancer Society*, "Danish Study: No Extra Cancer Burden for Homosexuals in Registered Partnerships," July 16, 2003, available at http://www.cancer.org/docroot/NWS/content/NWS_1_1x_Danish_Study_No_Extra_Cancer_Burden_for_Homosexuals_in_Registered_Partnerships.asp, accessed March 5, 2004 (finding may be due to Denmark's universal health care insurance and less discrimination against gays and lesbians; in 1989, Denmark became the first European country to legally recognize same-sex partnerships).

[138] Dean, *supra* note 128, at 120.

[139] IOM *Lesbian Health, supra* note 123; Dean, *supra* note 128, at 113; Vickie Mays and Susan Cochran, "Mental Health Correlates of Perceived Discrimination Among Lesbian, Gay, and Bisexual Adults in the United States," *American Journal of Public Health* 91 (November 2001), 1869-1876.

[140] O'Hanlan, *supra* note 125. These percentages may potentially underreport the actual incidence of violence, in part because lesbians may fear discrimination or inappropriate responses from police or prosecutors if they do report domestic violence incidents.

[141] Dean, *supra* note 128, at 125; National Coalition of Anti-Violence Programs, *Lesbian, Gay, Bisexual and Transgender Domestic Violence Programs* (New York: National Coalition of Anti-Violence Programs, 2002 Preliminary Edition), available at http://www.avp.org.

[142] Dean, *supra* note 128, at 115; L. Remez, "Levels of HIV Risk Behaviors Are Significantly Elevated Among Women Who Have Ever Had Sex with Women," *Family Planning Perspectives* 33 (March/April 2001), 91-92.

[143] Dean, *supra* note 128, at 123-124.

[144] For a state-by-state summary of state hate crime laws addressing sexual orientation and gender identity, see Human Rights Campaign, "Statewide Hate Crimes Laws," July 2003, available at http://www.hrc.org/Template.cfm?Section=Your_Community&Template=/ContentManagement/ContentDisplay.cfm&ContentID=13382, accessed February 18, 2004.

[145] Dean, *supra* note 128, at 107; IOM *Lesbian Health, supra* note 123. In an effort to address these issues, the Association of Reproductive Health Professionals dedicated the October 2001 issue of its quarterly magazine, *Health and Sexuality*, to lesbian health issues, available at http://www.arhp.org/healthcareproviders/onlinepublications/healthandsexuality/lesbianhealth/index.cfm?ID=202, accessed March 5, 2004; van Dam, *supra* note 133, at 11-19; Winnie Stachelberg, "Advancing A Lesbian Health Agenda," *Human Rights Campaign Quarterly* Spring 1996; *Health Concerns, supra* note 127.

[146] Dean, *supra* note 128, at 107; IOM *Lesbian Health, supra* note 123.

[147] See Elena N. Cohen and Alison Sclater, *Truth or Consequences: Using Consumer Protection Laws to Expose Institutional Restrictions on Reproductive and Other Health Care* (Washington: National Women's Law Center, 2003), 6, available at http://www.nwlc.org/pdf/TruthOrConsequences2003.pdf.

[148] For more information on women with disabilities, see Center for Research on Women with Disabilities (CROWD) (713) 960-0505, http://www.bcm.tmc.edu/crowd; U.S. Department of Health and Human Services, The National Women's Health Information Center, "Women with DisAbilities," available at http://www.4woman.gov/wwd/, accessed February 18, 2004; Janice Blanchard and Susan Hosek, *Financing Health Care for Women with Disabilities* (Santa Monica: RAND, 2003), available through http://www.rand.org/. For information on health care needs of people with disabilities generally, see Centers for Disease Control and Prevention, "Disabilities," available at http://www.cdc.gov/node.do?id=0900f3ec8000e01a, accessed March 6, 2004; Kristina Hanson and others, *Understanding the Health-Care Needs and Experiences of People with Disabilities: Findings from a 2003 Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, 2003), available at http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=28401, accessed March 5, 2004 [hereinafter Hanson]; U.S. Department of Health and Human Services, *Healthy People 2010 Volume I*, 2nd ed. (Washington: U.S. Department of Health and Human Services, 2000), 6-3 to 6-28, available at http://www.healthypeople.gov/document, accessed February 25, 2004 [hereinafter *Healthy People 2010*]; Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington: Center for Women and Policy Studies and Women and Philanthropy, 1999) [hereinafter Fiduccia].

[149] *NHDR, supra* note 2, at 206. Under the Americans with Disabilities Act (ADA), an individual with a disability is defined as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment, or a person who is perceived by others as having such an impairment. 42 U.S.C. § 12102(2); *A Guide to Disability Rights Laws* (Washington: U.S. Department of Justice, Civil Rights Division, Disability Rights Section, May 2000), 1. See also definitions of disability in notes to Chapter III, note 10 and "Women with Disabilities Affecting Workforce Participation" Data Source note in Methodology section of this *Report Card*.

[150] *Healthy People 2010*, supra note 148, at 6-5 to 6-7; Fiduccia, *supra* note 148, at 3 (stating that one of every five women in the United States is disabled).

[151] *Ibid.*, 8; Ronald L. Mace, *Removing Barriers to Health Care: A Guide for Health Professionals* (Raleigh: Center for Universal Design, undated), available at http://www.fpg.unc.edu/~ncodh/rbar/, accessed February 24, 2004.

[152] 42 U.S.C. § 12102(2) *et seq.*

[153] Fiduccia, *supra* note 148, at 8.

[154] *Ibid.*, 9; Hanson, *supra* note 148.

[155] Fiduccia, *supra* note 148, at 8.

[156] M.A. Nosek and others, *National Study of Women with Physical Disabilities: Final Report* (Houston: Center for Research on Women with Disabilities, Baylor College of Medicine, 1997), http://www.bcm.tmc.edu/crowd/national_study/national_study.html, accessed February 24, 2004 [hereinafter Nosek].

[157] *Healthy People 2010, supra* note 148, at 6-6, 6-7.

[158] Nosek, *supra* note 156.

[159] Fiduccia, *supra* note 148, at 25-29 (source for all the information in the paragraph text). For more information about sexual violence against people with disabilities, see Centers for Disease Control and Prevention, "Sexual Assault Against Persons Living with Disabilities," *Sexual Violence Prevention: Building Leadership and Commitment to Underserved Communities*, April 3, 2003, available at http://www.phppo.cdc.gov/PHTN/svprev/resmat.asp, accessed March 6, 2004.

[160] Fiduccia, *supra* note 148, at 10 (source for all the information in the paragraph text).

[161] For more information on women and HIV/AIDS generally, see Pamela Brown-Peterside and others, "Retaining Hard-to-Reach Women in HIV Prevention and Vaccine Trials: Project ACHIEVE," *American Journal of Public Health* 91 (September 2001), 1377-1379; *Women's Health USA 2003, supra* note 104, at 32-33 (citing data only as recent as 2001); Centers for Disease Control and Prevention, "Characteristics of Persons Living with AIDS and HIV, 2001", *HIV/AIDS Surveillance Supplemental Report* 9 No. 2 (2003), Table 1.

[162] Centers for Disease Control and Prevention, "Basic Statistics," *HIV/AIDS Surveillance Report*, December 2003, available at http://www.cdc.gov/hiv/stats.htm, accessed March 10, 2004.

[163] *Ibid.*

[164] National Institutes of Health, "HIV Infection in Women," May 2003, available at http://www.niaid.nih.gov/factsheets/womenhiv.htm, accessed March 21, 2004.

[165] The Henry J. Kaiser Family Foundation, "Women and HIV/AIDS," October 2003, 8, available at http://www.kff.org/hivaids/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21820, accessed March 22, 2004.

[166] Centers for Disease Control and Prevention, "HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk," March 27, 2003, available at http://www.cdc.gov/hiv/pubs/facts/women.htm, accessed March 22, 2004.

[167] Centers for Disease Control and Prevention, "HIV/AIDS Among African Americans," February 6, 2004, available at http://www.cdc.gov/hiv/pubs/Facts/afam/htm, accessed March 22, 2004.

[168] Centers for Disease Control and Prevention, "Heterosexual Transmission of HIV-29 States, 1999-2002," *Morbidity and Mortality Weekly Report* 53 (February 20, 2004), 125-129 (females accounted for 70 percent of such cases reported among non-Hispanic Whites, 64 percent among non-Hispanic Blacks, and 56 percent among Hispanics).

169 Jennifer Kates, "Women and HIV/AIDS in the U.S.: Update on Epidemiology and Key Trends," *Women and HIV/AIDS in the United States: Setting an Agenda for the Future* (October 23, 2003), Figure 8, available at http://www.kaisernetwork.org/health_cast/uploaded_files/102303_kff_women_jen_kates.pdf, accessed February 25, 2004.

170 Lake Snell Perry & Associates, Inc. and The Henry J. Kaiser Family Foundation, *The Healthcare Experiences of Women with HIV/AIDS: Insights from Focus Groups* (Menlo Park: The Henry J. Kaiser Family Foundation, October 2003), available at http://www.kff.org/hivaids/hiv3380report.cfm; Mark Schuster and others, "HIV-Infected Parents and Their Children in the United States," *American Journal of Public Health* 90 (July 2000), 1077-1079; Nancy Kass, "A Change in Approach to Prenatal HIV Screening," *American Journal of Public Health* 90 (July 2000), 1026-1027.

171 *NHDR, supra* note 2, at 154-155.

172 Martha Hargraves, "Elevating the Voices of Rural Minority Women," *American Journal of Public Health* 92 (April 2002), 514-515 [hereinafter Hargraves].

173 Michelle Casey and others, "Are Rural Residents Less Likely to Obtain Recommended Preventive Healthcare Services?" *American Journal of Preventive Medicine* 21 (2001), 182-188.

174 *Ibid.*

175 Mark Eberhardt and others, *Urban and Rural Health Chartbook: Health, United States, 2001* (Hyattsville: National Center for Health Statistics, 2001), 3-5, available at http://www.cdc.gov/nchs/data/hus/hus01.pdf, accessed February 20, 2004 [hereinafter Eberhardt].

176 *Ibid.*

177 Larry Gamm and others, eds., *Rural Healthy People 2010: A Companion Document to Healthy People 2010*, Vol. 1 (College Station: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003), 237-238.

178 *Ibid.*

179 Eberhardt, *supra* note 175, at 62.

180 *Ibid.*, 44.

181 *Ibid.*, 54.

182 Hargraves, *supra* note 172 (source for paragraph in text).

183 Unless otherwise indicated, the information from this paragraph is from Joann Morton, "Physical Health Issues of Women Offenders" and "Mental Health," in *Working with Women Offenders in Correctional Institutions* (Lanham: American Correctional Association, forthcoming 2004), available at http://www.aca.org [hereinafter Morton]; *Women's Health USA 2003, supra* note 104, at 59; National Criminal Justice Reference Service, "In the Spotlight: Women & Girls in the Criminal Justice System," available at http://www.ncjrs.org/wgcjs/summary.html, accessed February 18, 2004 [hereinafter "In the Spotlight"]; The Sentencing Project, "Women and the Criminal Justice System," available at http://www.sentencingproject.org/issues_10.cfm, accessed February 27, 2004; "Factsheet: Women in Prison," May, 2003, available at www.sentencingproject.org/pdfs/1032.pdf, accessed February 27, 2004; Amnesty International, *Abuse of Women in Custody: Sexual Misconduct and Shackling of Pregnant Women: A State-by-State Survey of Policies and Practices in the United States*, available at http://www.amnestyusa.org/women/custody/abuseincustody.html, accessed March 16, 2004.

184 *Women's Health USA 2003, supra* note 104, at 59 (growth in number of incarcerated women: 83,253 to 165,649).

185 Amnesty International, "Women in Prison: A Fact Sheet," undated, available at http://www.amnestyusa.org/women/womeninprison.html, accessed March 16, 2004.

186 "In the Spotlight," *supra* note 183.

187 *Women of Color Health Data Book, supra* note 6, at 6.

188 Patricia Allard, *Life Sentences: Denying Welfare Benefits to Women Convicted of Drug Offenses* (Washington: The Sentencing Project, 2002), available at www.sentencingproject.org/pdfs/9088.pdf, accessed March 12, 2004; Morton, *supra* note 183.

Methodology

1 American Cancer Society, *Cancer Facts and Figures 2003* (Atlanta: American Cancer Society, 2003), 13, available at http://www.cancer.org/downloads/STT/CAFF2003PWSecured.pdf.

2 See, e.g., "Grading," in National Center for Public Policy and Higher Education, *Measuring Up 2000: The State-by-State Report Card for Higher Education 2000*, available at http://measuringup.highereducation.org/2000/articles/grading.cfm. The goal was to scale the scores so that they could range between 0-100 for each indicator. The following description uses the consumption of fruits and vegetables indicator as an example to illustrate how the scaled scores were calculated for each indicator. The benchmark for the consumption of fruits and vegetables indicator is 50 percent. The state performances range from a high of 38.6 percent in the District of Columbia to a low of 16.8 percent in Oklahoma. The first step in calculating the scaled score is to express these raw data as a percentage difference from the benchmark. The District of Columbia is 22.8 percent short of the benchmark and Oklahoma is 66.4 percent short of the benchmark. The next step is to determine the number that, when multiplied by the worst state's percentage difference from the benchmark, equals 100. In the case of the consumption of fruits and vegetables, this figure is 1.506 (66.4 x 1.506 = 100). Each state's percentage difference from the benchmark is then multiplied by this figure. At this stage, the District of Columbia would receive 34.3 (22.8 x 1.506 = 34.3), and Oklahoma would receive 100 (66.4 x 1.506 = 100). Finally, the resulting number is subtracted from 100 to achieve the scaled score. The District of Columbia's scaled score for the consumption of fruits and vegetables is 65.7 (100 – 34.3 = 65.7) and Oklahoma's scaled score is 0 (100 – 100 = 0). (States that meet or exceed the benchmark receive a scaled score of 100.)

3 P.L. 108-173.

4 The term "institutionalized population" as used in the *Report Card* includes persons "under formally authorized, supervised care or custody, such as in federal or state prisons; local jails; federal detention centers; juvenile institutions; nursing, convalescent, and rest homes for the aged and dependent; and homes, schools, hospitals or wards for the physically handicapped, mentally retarded, or mentally ill." U.S. Census Bureau, Census of Population and Housing, 1990: Summary Tape File 3, Technical Documentation (Washington: U.S. Census Bureau, 1992) [CD-ROM].

5 In its use of "Black" and "African American," this *Report Card* has attempted to follow the source material's usage, wherever possible. There is some confusion over the use of the two terms, with sources using them inconsistently. Black women are primarily "African American," the term commonly used to describe the descendants of Africans brought to the United States as slaves. There is, however, increasing diversity among Blacks, with foreign-born Blacks accounting for six percent of all Blacks in the United States. Most other Blacks in America are of Caribbean descent, coming from island nations including the

Dominican Republic, Haiti, Jamaica, and Trinidad and Tobago. Recent immigrants from African countries account for less than four percent of all U.S. immigrants between 1981 and 1998, but there is some indication that these numbers are increasing. National Women's Law Center and others, *Making the Grade on Women's Health: A National and State-by-State Report Card, 2001* (Washington: National Women's Law Center, 2001), 201.

6 In 1997 and 2000 the Office of Management and Budget issued its "Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity" (Federal Register Notice October 30, 1997) and "Provisional Guidance on the Implementation of the 1997 Standards for Federal Data on Race and Ethnicity" (December 15, 2000) which direct that in the federal collection and reporting of data by race, respondents be permitted to specify multiple races.

7 David Smith and Gary Gates in their Human Rights Campaign report, "Gay and Lesbian Families in the United States: Same-Sex Unmarried Partner Households," August 22, 2001, available at http://www.urban.org/UploadedPDF/1000491_gl_partner_households.pdf analyzed these data for both lesbians and gays and found that the geographic and other response patterns correspond with what is known of the lesbian community.

8 Dan Black and others, "Demographics of the Gay and Lesbian Population in the United States: Evidence from Available Systematic Data Sources," *Demography* 37 (May 2000), 139-154.

9 A reasonable maximum from other evidence accumulated by Gates, et al.

10 According to the results of the 1994 membership survey of the American College of Nurse Midwives, about six percent of midwives reported that they were not identified as the attendant at delivery for some births that they attended. L.V. Walsh and others, "Findings of the American College of Nurse-Midwives, Annual Membership Survey, 1993 and 1994," *Journal of Nurse Midwifery* 41 (1996), 230-235.