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EXPANDING THE POSSIBILITIES

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WOMEN AND HEALTH COVERAGE: A FRAMEWORK FOR MOVING FORWARD

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INTRODUCTION AND EXECUTIVE SUMMARY

Health care coverage is back in the spotlight, in the wake of growing costs and increasing numbers of uninsured individuals. Public opinion polls show that the majority of all Americans, and women in particular, believe that addressing health care issues should be one of the nation's top priorities.

Currently, there are 44.8 million Americans without health insurance.[1] And though women are more likely than men to have health coverage, both insured and uninsured women are more likely than men to report difficulty obtaining health care because of cost.

The Commonwealth Fund and the National Women's Law Center have jointly authored an issue brief entitled ***Women and Health Coverage: The Affordability Gap***, which explores the difficulties women face in obtaining and affording health insurance. The National Women's Law Center's companion issue brief, ***Women and Health Coverage: A Framework for Moving Forward*,** evaluates efforts to expand health insurance in terms of their potential to address the particular challenges women face. Together these briefs demonstrate that the unmet health needs of women in this country are great, that reforms can be designed to meet the needs of women and that there is great variation among the proposals on the table with respect to their ability to meet women's needs.

THE AFFORDABILITY GAP

This issue brief demonstrates that health care affordability is a particular problem for women. They are more likely to need and use health services, but on average have lower incomes than men and therefore less financial ability to pay for their greater health care needs. At the same time, many women's health insurance coverage is precarious and incomplete. They are less likely to have insurance from their own employer and, regardless of what kind of coverage they have, they are more likely to have to make substantial out-of-pocket payments.

Highlights from ***Women and Health Coverage: The Affordability Gap*** show that there are several coverage patterns unique to women:

- **Almost as many women are uninsured all year as are uninsured for part of the year.** While 44.8 million people have no insurance for a whole year, many

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millions more people are uninsured for months at a time. One in four women are either uninsured for part or all of the year.

- **Women have less access to their own employer-sponsored insurance.** Thirty-five percent of uninsured women are not employed, compared to only 18% of uninsured men. While all part-time workers are less likely to be insured, only 13% of uninsured men work part-time while 22% of uninsured women work part-time.
- **Women are more likely to depend on their spouses for their insurance and therefore face more instability in their coverage**. Twenty-four percent of women get their insurance through their spouse's job, as compared to only 11% of men. Dependent coverage is not a stable source of insurance; in fact, between 2001 and 2005, employers dropping such coverage accounted for 11% of the decline in employer-sponsored insurance overall.[2]
- **More women than men purchase insurance in the individual market, which is more expensive than insurance in the group market**. Slightly more women than men purchase insurance in the individual market.[3] People who purchase individual health insurance do so because they have few alternatives, and yet those who have a greater need for health insurance face barriers in purchasing individual insurance coverage because they can be denied coverage altogether or charged extremely high rates.

Women face difficulty in affording care.

- **Women are more likely to have lower incomes than men.** Women are more likely to be poor. Seventeen percent of women ages 19-64 are below 100% of federal poverty level (FPL) compared to 13% of men in that age group.
- **Women use more health care services on average than men.** Women's reproductive health needs require them to get regular check-ups, whether or not they have children. Moreover, women of all ages are more likely than men to take prescription medications on a regular basis (60% versus 44%).
- **Women have higher out-of-pocket costs than men as a share of their income.** Although women have less income than men, women have more health care needs and use more services. Sixteen percent (16%) of all insured women, in contrast to 9% of all insured men, have high medical costs compared to their income and, therefore, are considered "underinsured."
- **Women are more likely to avoid needed health care because of cost.** Overall, women are more likely than men to have difficulty obtaining needed health care (43% vs. 30%)—a difference more pronounced for uninsured women (68% vs. 49%).Women are more likely than men to not see a doctor or specialist, fill a prescription, or get a medical test or treatment when needed.
- **Women are more likely to have medical bill and debt problems.** Among the uninsured, 56% of women report difficulty paying bills compared to 48% of men. Twenty-six percent of women compared to 19% of men were not able to pay their medical bills.

A Framework for Moving Forward

The facts demonstrate that women often fall through the cracks entirely in the current system or obtain coverage that is inadequate for their needs. With so many barriers to comprehensive and affordable health care, improvements are clearly necessary. Whether health care coverage reforms are incremental and build on the current health care system or create a new single universal health care system for all, the same issues of affordability and comprehensiveness of benefits must be addressed.

Coverage that is both affordable and comprehensive can be achieved in a number of ways. It is possible, for example,

to combine employer-sponsored coverage and public programs, or to create a new system that covers all individuals with the same plan. There are several characteristics in any plan, however, that are essential to meet the needs of the American public, and most especially women.

Regardless of what form expansion efforts take, the following questions must be asked to determine which policies would have the most positive far reaching effects for women. Does the policy:

- ✓ Assure that all individuals have coverage?
- ✓ Extend coverage to the uninsured without eroding the coverage of the insured?
- ✓ Utilize large groups so that the risk to any one individual is minimized?
- ✓ If building on employer-sponsored coverage, ensure that all employees, including part-time employees, and dependents have access to coverage?
- ✓ Enable individuals who are outside the labor force to obtain coverage?
- ✓ Provide subsidies to ensure that low-income individuals can afford health coverage?
- ✓ Ensure that health plans provide comprehensive benefits, including services that women need?
- ✓ Ensure that the out-of-pocket costs (e.g. co-payments and deductibles) are affordable relative to the individual's income?

Because the impact of proposals on women varies dramatically, these questions can serve as a tool to determine which policies would be most beneficial for them. A policy such as expanding Medicaid to cover more low-income parents would provide the especially needy women who qualify with coverage that is comprehensive and affordable, as the program's cost-sharing requirements are appropriately minimal given the low income of this population. To reach an additional set of women, a policy that allows businesses and individuals to buy into an existing large pool of insured individuals, such the Federal Employees Health Benefits Program (FEHBP), could provide affordable coverage because individuals would share the risk of their health costs with a large group of people, thereby keeping the cost of each person's premiums down. This plan could be designed to work more beneficially for women, given their lower incomes on average than men, by using sliding scale subsidies for premium costs and providing a range of benefits and cost-sharing plans. Furthermore, a universal single-payer system based on Medicare could be designed to ensure that all women have comprehensive and affordable coverage. Benefits would have to include the range of services that women need, like cancer screenings and maternity coverage, and cost-sharing requirements would have to be appropriate relative to women's incomes, in order to be most effective.

Conversely, answering the questions listed above would point out the weaknesses of other proposals under consideration. For example, offering tax credits to encourage women to buy into the individual market would not help very many women because such plans are expensive to purchase, even with the help of a tax credit, and usually have limited benefits and high cost-sharing requirements. Most women would incur large costs for their care, even if they were able to buy the coverage. Additionally, this type of approach could result in some women losing their employer-sponsored coverage because some employers would drop coverage for their employees if tax credits were made available to them.

As the review of the proposals below demonstrates, there are a number of particularly promising approaches that make the provision of health coverage for all an achievable goal. Policymakers should seize the opportunity presented by the public's need and demand for change to eliminate coverage gaps and provide comprehensive health coverage. With the number of uninsured and underinsured people growing annually, now is the time to implement policies that truly meet the needs of both women and men in this country.

Coverage Expansion Policies and their Effects on Women

With so many barriers to comprehensive and affordable health care, improvements are clearly necessary, though many questions remain as to how to achieve reform. The following analyzes a large range of health coverage expansion proposals, from newly created universal coverage plans to incremental proposals that affect a smaller number of people. Each policy is described and then analyzed for its effect on coverage generally and for its specific effect on women.

Expanding Health Coverage: Employer-Sponsored Health Insurance

One approach targets the expansion of employer-sponsored health insurance (ESI), the most common type of private health insurance in this country. Employers usually have a cross-section of employees of varying age and health status, which allows for the health risks of the employees to be "pooled" across the whole group. A number of proposals seek to encourage or require employers to offer coverage to their employees. However, none of them requires all employees to receive benefits, and consequently, most only help full-time employees. Given that many of the uninsured, particularly women, work part-time, policies that target employers but do not require the inclusion of part-time workers will not be as beneficial as they could be in lowering the number of uninsured workers.[4] In addition, employer coverage has been declining, especially for dependents, putting women at particular risk. Proposals targeting ESI include:

Association Health Plans

Policy: Some proposals focus on the types of employers that often do not offer coverage today, such as small businesses. Those that do, on average, offer fewer health benefits and require higher cost-sharing than larger firms.[5] On the state level, these proposals allow small businesses to band together at their choosing and create purchasing coalitions within a state. These coalitions give small employers the advantages of large ones, namely increased purchasing power, lower administrative costs and greater choice of plans for employees. At the federal level, there is an initiative that would create purchasing coalitions, known as Association Health Plans (AHPs). AHPs could buy insurance from insurance companies or become insurers themselves by paying claims from their own funds.[6] As they have been currently designed, AHPs are subject only to very minimal federal regulations. They could offer insurance across state lines and be exempted from state insurance regulations, which generally include comprehensive consumer protections and important benefit mandates.

Effects on Coverage: Because AHPs might help lower rates for small businesses, this approach could help more people secure access to insurance. Since they are not subject to state regulations, they are likely to result in benefit packages that are not comprehensive and therefore result in high out-of-pocket costs for the individual employee. If benefit mandates and consumer protections in the small group market did apply to AHPs, this approach would be more beneficial for employees.

Effects on Women's Coverage: For women working in small businesses who are relatively healthy, AHPs may create insurance options that previously did not exist. However, AHPs do not have to accept all businesses, so companies with more women, who use more services, or with sicker individuals may be left out or charged unaffordable premiums. Finally, because AHPs are exempt from state benefit mandates and other consumer protections, women, who are the primary beneficiaries of laws that, for example, require coverage of maternity care or breast cancer treatment, would be disproportionately affected.

Buying into the Federal Employee Health Benefits Program

Policy: This policy option would allow small businesses or individuals to buy into the Federal Employee Health Benefits Program (FEHBP), the health plan the federal government provides its employees.[7] Generally, such proposals require insurers that offer coverage through FEHBP to do so for eligible individuals (i.e., the pool is built

on, but not mixed with, the existing FEHBP pool). A variation on this proposal provides small businesses, particularly those with a large proportion of low-income workers, a subsidy to help them to buy into the program for their employees.

Effects on Coverage: This policy would provide comprehensive insurance to individuals who, on their own or through their employer, could afford to buy into the FEHBP. Some opponents, however, believe that allowing broad buy-in to FEHBP would undercut the entire program because too many sick people would enter the system, thereby resulting in higher premiums for all participants.[8] To prevent higher premiums for current FEHBP participants, a parallel program would have to be created, although the pool would include, on average, sicker people, thereby resulting in more expensive premiums for its participants.

Effects on Women's Coverage: This approach, like AHPs, would give women greater access to employer-based coverage. They would likely have a greater choice of plans than offered through traditional ESI and AHPs since FEHBP's size attracts a number of large health plans. However, subsidies for small businesses with low-income women would need to be substantial to make coverage affordable.

Requiring Employers to Provide Coverage

Policy: Some states have promoted access to ESI by directly requiring an employer to provide health coverage for their workers or pay a fee to the state as a penalty so that their employees can be covered by public insurance.[9] This approach has been considered and/or passed in several states.[10] For example, Maryland passed a law in 2006 which required businesses with more than 10,000 employees in the state to spend at least 8% of their payroll on employee health benefits or pay into a fund for the uninsured. This law was subsequently struck down by a federal court and is currently on appeal. Similarly, Vermont passed a law to require employers to pay an annual assessment for each full-time equivalent employee if the company does not offer insurance to its employees. *(See Appendix Table A.)*

Effects on Coverage: This approach, if applied broadly to all employers in a state, could have the practical effect of providing access to all workers. However, given that recent proposals and laws limit the requirement to large employers, individuals working in small businesses, who are less likely to have access to ESI, will not benefit.

Effects on Women's Coverage: Requiring employers to provide coverage helps women who themselves are employed or whose spouses are employed but are not receiving ESI. However, unless the employer's contribution is substantial, the newly available insurance may not be affordable for women as employees. In addition, a larger fraction of women than men do not work. If these women are not eligible for coverage as a dependent, or that dependent coverage is not affordable, then they will be left out of the system.

COBRA coverage expansions

Policy: Under federal law, most employers that provide ESI and have 20 or more employees must offer employees and their families the option of continuing the insurance at group rates when faced with the loss of coverage because of certain events.[11] The length of coverage depends on the event (e.g. if the event is death of or divorce from the worker, 36 months of coverage for the worker's beneficiary is required). Employers may charge employees or family members 102% of the otherwise applicable premium. States can go beyond the federal law and extend the amount of time employees qualify for COBRA because of specific events such as divorce. Specifically, policies extend COBRA to older people at pre-Medicare age so as to provide coverage to individuals until they become eligible for Medicare at age 65 or are covered by another insurance plan. *(See Appendix Table A.)*

Effects on Coverage: COBRA has proven itself to be an important means for keeping people insured during

periods of unemployment. Any policy that extends the scope of COBRA therefore benefits uninsured workers and their families. This is especially true of those that have a history of health problems or high health care needs, since the pooled premium of COBRA will be less expensive than the individual market and access is guaranteed. However, one of the main reasons cited for not continuing coverage through COBRA is cost.[12] Therefore, although this policy option does make insurance available, it does not address affordability.

Effects on Women's Coverage: Policies that extend the amount of time employees and their dependents qualify for COBRA would be beneficial to women, specifically for older and/or divorced women as well as those with high costs or risks. Given that women are more likely to rely on a spouse's ESI, extending this COBRA option would help women remain insured, if they can afford the premium,[13] until they are old enough to qualify for Medicare.

Health Savings Accounts

Policy: Another approach to making health coverage available is the creation of Health Savings Accounts (HSAs). Federal tax benefits are provided to HSAs, which are specific accounts funded by the employer and/or employee to be used by the employee to purchase health services. These accounts are designed to be combined with a health plan that has a high deductible.[14] Employers can offer HSAs as the only form of coverage for their employees or they can be provided as an alternative for an employee to participating in the comprehensive ESI plan. Employers may favor these accounts[15] because premiums for high-deductible plans are less than premiums for comprehensive coverage. Proponents of HSAs would like to see further tax benefits created in order to promote the use of these accounts and expand their scope to reach individuals in other insurance markets. In fact, these accounts, often referred to as "consumer directed arrangements" can be used in some form for all types of coverage, including the individual market[16] and Medicare and Medicaid.

Effects on Coverage: Because the funds in the HSAs belong to the individual, they are portable and remain with the individual to be used to cover their medical expenses, regardless of whether he or she changes employers or the new employer offers HSAs.[17] However, people with less income to contribute to the HSA may not have enough funds in their accounts to cover their health care needs in a given year. Also, depending on the design of the high-deductible plan, there may be holes in coverage that will require individuals to pay substantial out-of-pocket costs until they meet the high deductible and the plan begins reimbursing for services. While the main goal of an HSA is to discourage the overuse of services, increased cost-sharing has been shown to lead to the under use of needed services, particularly for those with low incomes and those with chronic illnesses.[18] In fact, a recent examination of early experiences with HSAs has also shown that such accounts tend to primarily benefit individuals with higher incomes and in good overall health.[19]

Effects on Women's Coverage: The fact that HSAs are portable benefits women in particular as they are more likely than men to cycle in and out of the labor force. However, women with less disposable income and/or higher health care needs are less well-served by an HSA than a comprehensive ESI plan primarily, because they will face higher out-of-pocket payments from the high-deductible plan and are less likely to be able to cover the difference through their tax savings. Because women typically need and use more health care than men, high out-of-pocket costs can discourage needed health care use for women. Additionally, women may be less likely to use preventive services—key to early detection and treatment of disease—if faced with high cost-sharing.

Expanding Health Coverage: The Individual Insurance Market

A second approach is to expand the individual insurance market. Proponents of this approach argue that ESI, by linking insurance to work, encourages "job lock," preventing people from changing jobs or work status for fear of losing coverage. And, as discussed above, ESI is less accessible for certain groups, such as those who work part-time or are self-employed. Moreover, in the individual market, eligibility and initial premiums are usually based on the individual's health status and risk characteristics, thereby making coverage difficult to obtain or very expensive if the

person has any negative medical history. Also, plans in this market often offer only minimal benefits and high cost-sharing. Changes to the individual market include:

Tax Credits for the Individual Market

Policy: One prominent proposal for increasing affordability of health coverage provides tax credits to individuals that they can use to purchase health insurance in the individual market. These credits, which would be available to those who do not have access to ESI or public programs, would total up to $1,000 for individuals and $2,000 for families. They would be phased out for middle-income people.[20] Also, most proposals make the tax credit refundable, which would benefit individuals whose incomes are low enough that they do not pay income taxes.

Effects on Coverage: Given that the individual market can be expensive, this tax credit would help to make individual insurance more affordable. However, individual insurance is often unavailable because even minor conditions can be grounds for denial of coverage. There is also potential that job-based health insurance will become less affordable as a consequence of this policy.[21]

Effects on Women's Coverage: Studies have found that low-income women would face extraordinary difficulties in securing affordable health coverage in the individual insurance market even if assisted by tax credits of a $1,000 a year.[22] Women are usually quoted higher premium rates than men and if maternity coverage is needed, the premiums are even higher.[23] Another common problem for women in this market is underinsurance. Women face high out-of-pocket costs as plans often contain carve-outs for maternity coverage, caps on prescription drugs and limitations or exclusions of certain kinds of services, such as mental health.

Regulations for the Individual Market

Policy: States can enact protections for people seeking to buy insurance in the individual market. The two most common regulations require that plans be sold on a "guaranteed issue" basis, which provides access to coverage for all applicants regardless of health status, or through "rating restrictions," which limit the amount a premium can vary based on gender, age or health status.[24] *(See Appendix Table B.)*

Effects on Coverage: Both of these approaches would make individual plans accessible to high-risk populations, including moderate-income, chronically-ill individuals who might otherwise not be able to afford the premiums. However, out-of-pocket costs in the individual market would still be high compared to those associated with employer coverage. There is also evidence to suggest that such regulations in the individual market lead to increased costs for healthy applicants.[25]

Effects on Women's Coverage: Given that women are more likely to be low-income and have chronic illnesses, while these regulations would help some women gain access to health coverage on the individual market, high premiums would remain a barrier for many women. In addition, while women could gain insurance, they may be underinsured, still paying a large fraction of income on health care, and lacking coverage for critical services.

Tax Deductions to Encourage People to Purchase Individual Insurance

Policy: This proposal would allow any taxpayer who obtains qualifying health insurance[26] to receive a standard deduction of $15,000 for a family and $7,500 for an individual. The deduction would be allowed regardless of the costs of health insurance policy and whether the insurance plan was purchased through an employer or on the individual market.[27]

Effects on Coverage: This proposal would primarily help those already purchasing coverage through the individual market as it would reduce taxes for this group. But the proposal does not help make individual coverage more affordable to those who currently cannot access it, due to either low-income or health conditions. Because the proposal is a tax deduction rather than a tax credit, it would only help those individuals who earn enough to pay

taxes. Given that over half of the uninsured have no tax liability, this proposal would not help them. Another concern is the effect such a policy could have on ESI. Because the deduction is a set amount and is not indexed to rise with health care costs, over time, more workers would be required to pay taxes on benefits that exceed the limited deduction. This limited deduction could lead employers to cap their contributions to employee health benefits and offer less comprehensive plans.

Effects on Women's Coverage: This policy will not help those women who lack ESI obtain comprehensive coverage in the individual market. Given that women's incomes tend to be lower than men's, women will be less likely to benefit from a tax deduction than they would from a tax credit and even less likely to benefit enough to afford an individual health plan. Furthermore, the potential impacts on the employer-sponsored system could also affect the comprehensiveness of ESI which would negatively impact women.

Expanding Health Coverage: Public Programs

The third approach is to expand public programs to cover more people. Currently, public insurance is limited to those that meet certain state and federal requirements. For example, the Medicaid program reaches select populations (i.e. children, pregnant women, parents of dependent children, elderly and people with disabilities) at specified and typically very low income levels. Medicare is restricted to the elderly and certain people with disabilities. These rules could be changed. However, since both types of coverage come with larger government subsidies than is available in ESI and the individual market, budget costs tend to raise concerns among policymakers. Proposals to expand public programs include:

Extending Medicaid to Low-Income Parents

Policy: Expanding the eligibility for Medicaid could insure a large fraction of low-income families,[28] nearly half of whom are uninsured. States can raise the income eligibility level for low-income parents, which in most states is well below the eligibility level for children.[29] To encourage states to insure more low-income parents, the federal government could increase federal funding to states for this purpose. *(See Appendix Table C.)*

Effects on Coverage: Allowing parents to qualify for Medicaid along with their children would improve insurance rates for low-income families. Research shows that Medicaid coverage is essential not only to the health of parents but also to the health of their children, who are more likely to be enrolled and get services if their parents are also enrolled.[30] Unfortunately, a new federal law, the Deficit Reduction Act of 2005, has given states the ability to make significant changes in Medicaid benefit packages and cost-sharing requirements, which could affect the comprehensiveness and affordability of Medicaid coverage.

Effects on Women's Coverage: A quarter of uninsured women are mothers whose income is low enough that their children are eligible for Medicaid or SCHIP,[31] although they themselves do not qualify. Medicaid, therefore, can play an important role for women, who are more likely to be the custodial parent. In particular, extending Medicaid to cover more low-income parents would reach many low-income women who are working. It would also reach women who would otherwise not be helped by policies that use the tax code to provide subsidies, given that such policies leave a significant premium to be paid by the individual. Finally, Medicaid protects women from high out-of-pocket costs by limiting the amount of co-payments that beneficiaries can be charged. However, because states would have to decide whether to take this option, coverage would depend on where a woman lives, perpetuating the variability that occurs in today's Medicaid program. In addition, this policy may be viewed as unfair since it targets higher-income women with dependents rather than lower-income women without them.

Public Insurance for Adults Without Children

Policy: Adults without children comprise a high percentage of the uninsured partly because federal law does not allow Medicaid coverage for non-disabled adults under age 65 who do not have children. To expand coverage to

this population, states must secure a budget-neutral waiver of federal law or provide coverage using only state funds. States could address these gaps by creating a publicly-funded health insurance option for uninsured low-income adults regardless of their parental status, age or disability. In addition, Congress could make covering this population a new state option and, to encourage states' use of the option, increase its matching payments for it. *(See Appendix Table C.)*

Effects on Coverage: This policy would help insure low-income individuals who do not have families. Because Medicaid tends to have comprehensive benefits, access to services would be largely guaranteed. However, low-income non-disabled adults without children are often low on the priority list for public money and the programs they fund.

Effects on Women's Coverage: This policy would insure the poorest women in the nation who have a high rate of uninsurance. It also helps those who are no longer eligible for Medicaid (as their children are no longer "dependents") and yet are still not old enough to qualify for Medicare in their own right.

Creating Medicare Buy-in for Uninsured ages 55 to 65

Policy: To cover the rising number of uninsured older Americans, the federal government could allow people ages 55 to 65 to buy into Medicare by paying a premium. Proposals differ in their eligibility rules within this age group as well as the amount of premium assistance that would be provided for lower-income, older adults.

Effects on Coverage: Older uninsured adults are particularly vulnerable to health problems yet are less likely to have access to job-based health insurance or be able to afford the high premiums they face in the individual market. Therefore, creating an option for older people to obtain comprehensive coverage could insure many vulnerable individuals. There is concern, however, similar to FEHBP buy-in programs, that because more people in poor health would join the pool, such an option would raise the premiums for all participants. In addition, Medicare's benefits are less than FEHBP's in some areas (e.g., mental health coverage).

Effects on Women's Coverage: Given that both age and gender are taken into account when premiums are determined on the individual market, older women face much higher costs than the general population in securing such coverage. Allowing beneficiaries buy in to Medicare before age 65 is an affordable option for women, as a high proportion of 50 to 64 year old women whose husbands are on Medicare are themselves uninsured.[32] It could also create continuity in coverage, since Medicare will become this age group's primary insurer after they become 65. However, depending on what premiums are charged, affordability might still be a barrier.

Making Coverage Universal

Each of the aforementioned incremental policy proposals targets a subsection of people lacking affordable and comprehensive insurance. However, designing a new universal health system from the ground up could be the best way to provide for the health care needs of all women and men. In order to reach everyone, a universal approach must either completely redesign our health care system, or combine several incremental policy options. Proposals that make coverage universal include:

Creating a New System Based on Medicare or the Individual Market

Policy: A number of proposals assume that our system is broken beyond repair and needs to be simplified as well as expanded for all people. Each proposal could be designed in such a way as to be affordable for all, assuming the appropriate level of financial commitment from the federal government would be forthcoming. In addition, they could, through regulation or insurance pooling, ensure that options are available to all. Some favor adopting a **single-payer system**. The delivery of care would operate much like Medicare, where private entities provide care and are paid directly by the federal government. Financing of single payer proposals differ but usually involve a

combination of a tax on employers and individuals. The other major approach is an **individual insurance system**, in which everyone buys their coverage on the individual market. Proposals typically combine a regulated individual market with tax credits and use competition among private plans to set benefits and lower costs. In both systems, every person would be required to participate.

Effects on Coverage: Proponents argue that a single-payer system would lower health care costs through its ability to negotiate prices, while those favoring the individual insurance system believe that the market would control costs. Because of their scope, each of these approaches presents challenges. They would require extensive changes in the insurance industry, employer-employee relationship and funding streams of coverage. Because they both disrupt existing payment systems and cover all people, the cost to the federal government would be high. Benefits would be set quite differently—the government determining them in a single-payer system, and private plans doing so in the individual market system. If insurers compete on attracting healthy people, they could discourage sick people from enrolling by limiting coverage of the types of benefits these people need.

Effects on Women's Coverage: Under either policy option, the degree to which the benefits and costs are expected to be shared by the individual would determine its effect on women. However, as discussed earlier, women tend to face greater challenges in the individual market. And Medicare's benefits need modification to ensure women's health care needs are met.

Building on FEHBP and Medicaid

Policy: One comprehensive approach seeks to provide coverage to all Americans by building on ESI and the Medicaid program. All insurers who offer coverage through the FEHBP would be required to offer group coverage through a new national insurance pool. This pool would allow all individuals who lack ESI (including those who currently buy their insurance in the individual market) as well as all employers who want to provide ESI, to buy comprehensive coverage from this nationwide group. To ensure affordability, the proposal includes a refundable tax credit, which would be applicable to people in ESI plans as well as individuals obtaining individual insurance through the pool. The plan expands the Medicaid program as a safety net for all those below a certain income level. It abandons the current structure of the program that limits it to only certain categories of people (e.g. parents) and increases the federal contributions to the program so as to not overburden state budgets.

Effects on Coverage: This policy proposal would cover all Americans and provide subsidies to those who face financial barriers to care. This approach maintains the complexity of the nation's health care system by keeping in tact different types of insurance with different benefits and eligibility rules. This effect is both a strength and a weakness. Because it builds on the current system, it may be easier to implement than other proposals for universal coverage. However, many believe that the piecemeal nature of our system is what keeps it from providing quality and comprehensive health care to everyone.

Effects on Women's Coverage: Because of women's changing situations through their lifespan, particularly their movement in and out of the labor force and changing family status for dependent coverage, this policy could be designed to guarantee affordable and comprehensive benefits regardless of where women fall within the system. However, their access to benefits would vary depending on their health plan choice, age and other characteristics.

State Universal Health Coverage Initiatives

Policy: An alternative to a national plan to insure all people is to encourage states to do so. With or without federal assistance, states could develop comprehensive approaches to coverage for all their residents. Hawaii had such a system in the past. Several states[33] are in the process of attempting this type of coverage. Massachusetts is currently leading the pack, as it passed a law in 2006 that requires all residents to have health insurance[34] and created several options for its residents to obtain insurance. The law includes subsidies to help low-income individuals with income

up to 300% of poverty buy insurance. The law also contains a requirement that most employers help pay for health insurance or face a penalty of $295 a year per worker. The law anticipates that new insurance plans will be developed at an affordable rate for individuals who need to buy coverage on their own. Other states are considering similar approaches or variations of their own. Some propose federal funding and waivers of existing laws to facilitate action at the state level. Some policymakers predict that state plans will lead to models that eventually can be adopted at the national level.

Effects on Coverage: Unlike the federal government, states are pursuing ways to get all their residents insured. However, states will require a large infusion of new federal dollars to achieve such coverage.[35] Without new funds, it is likely that only those states with relatively small uninsured populations, like Massachusetts, could afford to launch their own universal coverage plans. Also, the overall impact on coverage will likely be small in states with large numbers of low-income people unless the necessary financial support for these individuals is available.

Effects on Women's Coverage: The effect of a state approach on women's coverage depends on the policy approach. Women are at greater risk of losing coverage if employers continue dropping dependent coverage and states continue to cut back on Medicaid benefits and eligibility due to cost. But the success of such state approaches to coverage for women, given their needs, is largely dependent on whether there are sufficient state and federal financial resources available to assure the comprehensiveness and affordability of plans.

Conclusion

For women, policy initiatives could have far-reaching benefits if they addressed the challenges that women face in obtaining and affording coverage, as described in the companion issue brief entitled ***Women and Health Coverage: The Affordability Gap***. The same issues of affordability and comprehensiveness of benefits must be addressed whether health care coverage reforms are incremental and build on the current health care system or create a new single universal health care system for all. Regardless of what form these expansion efforts take, the following questions must be asked to determine which policies would have the most positive far reaching effects for women.

Does the proposal:

- ✓ Assure that everyone has coverage?
- ✓ Extend coverage to the uninsured without eroding the coverage of the insured?
- ✓ Utilize large groups so that the risk to any one individual is minimized?
- ✓ If building on employer-sponsored coverage, ensure that all employees, including part-time employees and dependents, have access to coverage?
- ✓ Enable individuals who are outside the labor force to obtain coverage?
- ✓ Provide subsidies to ensure that low-income individuals can afford health coverage?
- ✓ Ensure that health plans provide comprehensive benefits, including services that women need?
- ✓ Ensure that the out-of-pocket costs (e.g. co-payments and deductibles) are affordable relative to the individual's income?

Because the impact of proposals on women varies dramatically, these questions can serve as a tool to determine which policies would be most beneficial for them. A policy such as expanding Medicaid to cover more low-income parents would provide women that qualify with coverage that is comprehensive and affordable, as the program's cost-sharing requirements are appropriately minimal given the low-income of this population. To reach an additional set of women, a policy that allows businesses and individuals to buy into an existing large pool of insured individuals, such the Federal Employees Health Benefits Program (FEHBP), could provide affordable coverage

because individuals would share the risk of their health costs with a large group of people, thereby keeping the cost of each person's premiums down. This plan could be designed to work more beneficially for women, given their lower incomes on average than men, by using sliding scale subsidies for premium costs and providing a range of benefits and cost-sharing plans. Furthermore, a universal single-payer system based on Medicare could be designed to ensure that all women have comprehensive and affordable coverage. Benefits would have to include the range of services that women need, like cancer screenings and maternity coverage, and cost-sharing requirements would have to be appropriate relative to women's incomes, in order to be most effective.

Conversely, answering the questions listed above would point out the weaknesses of other proposals under consideration. For example, offering tax credits to encourage women to buy into the individual market would not help very many women because such plans are expensive to purchase, even with the help of a tax credit, and usually have limited benefits and high cost-sharing requirements. Most women would incur large costs for their care, even if they were able to buy the coverage. Additionally, this type of approach could result in some women losing their employer-sponsored coverage because some employers would drop coverage for their employees if tax credits were made available to them.

Providing health coverage for everyone is an achievable goal. Policymakers should seize the opportunity presented by the public's need and demand for change to eliminate coverage gaps and provide comprehensive health coverage. With the number of uninsured and underinsured people growing annually, now is the time to implement policies that truly meet the needs of both women and men in this country.

Endnotes

1 Unless otherwise noted, all data in this summary is from Elizabeth M. Patchias and Judy Waxman, The Commonwealth Fund, "Women and Health Coverage: The Affordability Gap," April 2007.

2 Lisa Clemans-Cope *et al.*, Kaiser Commission on Medicaid and the Uninsured, "Changes in Employees' Health Insurance Coverage, 2001-2005," October 2006.

3 Analysis of the March 2005 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund (5.4 million versus 4.9 million).

4 The exclusion of part-time workers is not an issue with proposals that are not employer based, as an individual's employment status is not related to whether he or she accesses health insurance.

5 Dawn M Gencarelli, *Health Insurance Coverage for Small Employers* (Washington: The George Washington University, National Health Policy Forum, April 2005) [hereinafter Gencarelli].

6 Currently, there are a small number of associations that offer health benefits to their members in a similar fashion. This option provides those who do not have employer-sponsored insurance access to group insurance through their membership in a labor union, professional association, club or other organization.

7 Some proposals require that all insurers who participate in FEHBP open up their plans to individuals, while others require the insurers to offer group coverage through a national insurance pool which would be open to anyone who lacks ESI.

8 This outcome, known as adverse selection, refers to the problem of attracting members who are sicker than the general population and who therefore have higher than average costs. Given that premiums are based on the average risk of the entire group, premiums for everyone will go up under such a scenario.

9 Employers either reimburse the state for coverage of its employees by Medicaid or they pay into an account which funds a specially created public health insurance program for the uninsured.

10 Such a requirement is a component of the recently passed Massachusetts law, which will be discussed in greater detail later.

11 This law is part of the Consolidated Omnibus Budget Reconciliation Act, known as COBRA (29 USCS 1161 et seq).

12 Jennifer N Edwards *et al.*, The Commonwealth Fund, "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care," August 2003.

13 One of the main reasons cited for not continuing coverage through COBRA is cost. *Ibid.*

14 Tax-exempt Health Savings Accounts (HSAs) were created by the Medicare Modernization Act of 2003 (Public Law 108-173 [H.R. 1] December 8, 2003). They must be paired with a health plan carrying a deductible of at least $1,000 for an individual policy and $2,000 for a family policy. Both individuals and employers may contribute to an HSA, with a different maximum annual contribution for individual coverage and for family coverage. Withdrawals from an HSA may be made at any time and are excluded from taxable income if they are used to pay for qualified medical expenses. Individuals may roll over funds from one HSA to another without penalty.

15 Alternatively, an employer can set up an account (called a Health Reimbursement Account) that functions like an HSA, but does not have the tax advantages of an HSA and is owned by the employer. Employers may favor such accounts because they are not portable and therefore a departing employee will not take the funds with her.

16 The use of HSAs in the individual market raises issues for women because of the limited and expensive coverage, specifically with benefits such as maternity care, that exists in that market.

17 Withdrawals from an HSA are not taxed if they are used to pay for qualified medical expenses; withdrawals for non-qualified expenses are subject to regular tax as well as a 10 percent penalty, which is waived if the HSA owner dies, becomes disabled or is eligible for Medicare.

18 A recent study found that those in high-deductible health plans were more likely to have high out-of-pocket payments and to avoid or delay care. Paul Fronstein and Sara Collins, The Commonwealth Fund, "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," December 2005.

19 Government Accountability Office, "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans," GAO-06-798, August 8, 2006.

20 The full credit would only to be available to those individuals making $15,000 or less a year and families making $25,000 or less a year. The credit continues to phase down as income rises and phases completely out when income reaches $30,000 for individuals and $60,000 for a family of four.

21 Tax credits may have the unintended effect of causing younger and healthier workers to opt out of ESI, leaving the pool of workers in the employer plans a sicker and older group on average. This would drive up the cost-per-covered-worker that these firms face in providing ESI and would, in turn, raise costs for everyone in those plans.

22 Sara Collins *et al.*, *Health Insurance Tax Credits: Will They Work for Women?* (New York: The Commonwealth Fund, December 2002); FamiliesUSA, *A 10-Foot Rope for a 40-Foot Hole, Tax Credits for the Uninsured* (Washington: FamiliesUSA, September 2001).

23 This extra premium is known as a rider.

24 Rating restrictions fall into three broad categories: a) pure community rating allows premiums to vary only based on geography, family size and benefit

packages, b) modified community rating allows premiums to vary based on age and gender, c) rating bands allow varying premiums but limit the amount that is charged (e.g. a person in poor health can not be charged more than twice the premium of a healthy individual). Gencarelli, *supra* note 5.

25 Please see the Massachusetts example in Nancy C. Turnball and Nancy M. Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market, Short Case Studies of Six States* (New York: The Commonwealth Fund, February 2005).

26 Insurance would have to meet minimum standards to qualify for the deduction.

27 Currently, employer-based coverage is not included in taxable income at all.

28 Low-income is defined as having an income of 200% of the federal poverty level or below.

29 In 2005, the median income eligibility level for working parents was only 65% of FPL. National Women's Law Center, "Poor Parents on Medicaid Targeted for Cuts," February 2006.

30 Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (Washington: Kaiser Commission on Medicaid and the Uninsured, July 2004).

31 SCHIP is the State Children's Health Insurance Program, which is a federal grant to the states that allows for the coverage of certain low-income children.

32 Cathy Schoen *et al.*, The Commonwealth Fund Taskforce on the Future of Health Insurance, "Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70," January 2000).

33 Vermont has also passed a comprehensive health reform law that seeks to cover all its residents. Other states that are considering such laws include Pennsylvania, California and New York.

34 Individuals that do not purchase coverage by 2008 will face a penalty.

35 See Judy Solomon, Center on Budget and Policy Priorities, "President's 'Affordable Choices' Initiative Provides Little Support for State Efforts to Expand Health Coverage," April 2007.

Appendix Table A: State Policies for Employer-Sponsored Insurance

State	# of Adults (19-64) with ESI		% of Adults (19-64) with ESI		Policy that Requires Some Employers to Provide Insurance *(see page 5)*	COBRA Expansion *(see page 5)*
	Men	Women	Men	Women		
Alabama	869,290	916,900	65%	64%		
Alaska	114,130	119,260	58%	61%		
Arizona	923,100	984,160	57%	58%		
Arkansas	450,310	461,120	58%	57%		
California	6,097,030	6,211,100	57%	57%		✔
Colorado	912,180	926,990	64%	65%		
Connecticut	707,650	773,380	70%	71%		
Delaware	172,180	185,780	70%	71%		
District of Columbia	106,120	119,030	61%	62%		
Florida	2,812,580	3,037,660	57%	59%		
Georgia	1,679,780	1,837,220	65%	66%		✔
Hawaii	260,010	268,290	72%	72%	✔	
Idaho	251,260	264,170	62%	62%		
Illinois	2,587,200	2,616,750	68%	69%		✔
Indiana	1,281,020	1,288,650	69%	68%		
Iowa	624,420	625,780	71%	70%		
Kansas	552,720	548,570	69%	67%		
Kentucky	752,830	798,720	61%	63%		
Louisiana	757,060	771,370	61%	56%		
Maine	241,630	249,090	62%	62%		
Maryland	1,135,750	1,262,360	69%	72%		✔
Massachusetts	1,331,130	1,402,190	67%	70%	✔	
Michigan	2,101,280	2,126,380	71%	69%		
Minnesota	1,174,270	1,188,170	72%	74%		✔
Mississippi	480,670	526,130	58%	60%		
Missouri	1,115,910	1,159,380	67%	67%		✔
Montana	147,660	153,990	53%	54%		
Nebraska	344,830	346,020	67%	66%		
Nevada	475,280	453,200	66%	65%		
New Hampshire	305,140	314,420	77%	77%		✔
New Jersey	1,825,450	1,938,890	70%	72%		
New Mexico	286,370	299,930	52%	52%		
New York	3,506,890	3,780,360	62%	63%		
North Carolina	1,517,840	1,626,980	61%	62%		
North Dakota	125,030	125,200	65%	65%		
Ohio	2,404,000	2,532,460	72%	71%		
Oklahoma	571,000	622,470	59%	60%		
Oregon	688,050	691,840	62%	63%		✔
Pennsylvania	2,540,920	2,582,970	71%	69%		
Rhode Island	207,050	225,310	67%	67%		
South Carolina	725,470	784,370	61%	62%		
South Dakota	135,740	142,900	63%	64%		
Tennessee	1,060,980	1,072,950	59%	58%		
Texas	3,728,070	3,801,270	57%	56%		
Utah	464,320	474,310	67%	69%		
Vermont	119,070	126,000	63%	65%		
Virginia	1,505,530	1,577,950	68%	68%		
Washington	1,211,490	1,236,990	64%	64%		
West Virginia	313,300	332,700	58%	61%		
Wisconsin	1,161,860	1,166,880	69%	70%		
Wyoming	96,150	94,620	64%	62%		
United States	**54,636,380**	**57,273,600**	**63%**	**63%**	**2**	**8**

KEY:
Policy that Requires Some Employers to Provide Insurance: *States receive a check if they have a policy that requires some employers to provide health insurance to their employees.*
COBRA Expansion: *States receive a check if they extend the amount of time some individuals are eligible to receive COBRA in the event of divorce.*

SOURCES:
 # and % of adults with ESI: Estimates based on 2004 and 2005 Current Population Survey data, available at http://www.statehealthfacts.org. In March 2007, the U.S. Census Bureau identified an error in the health coverage data produced by their Current Population Surveys from 1995-2005, which overstate the uninsured nationally by 0.6 percentage points. Data presented here reflect this error, although corrected data are expected after the publication date of this Issue Brief.
Policy that Requires Some Employers to Provide Insurance: Data collected by the National Women's Law Center, March 2006.
COBRA Expansion: Georgetown University Health Policy Institute, 2006.

Appendix Table B: State Policies for Individual Private Insurance

State	# of Adults (19-64) with Individual Coverage		% of Adults (19-64) with Individual Coverage		Guaranteed Issue *(see page 7)*	Rating Restrictions *(see page 7)*	% of Private Sector Establishments Offering Insurance	
	Men	Women	Men	Women			Fewer Than 50 Employees	More Than 50 Employees
Alabama	50,970	64,600	4%	4%			44.8%	97.4%
Alaska	8,930	8,670	5%	4%			34.8%	95.4%
Arizona	129,490	127,990	8%	8%			38.5%	91.9%
Arkansas	46,450	50,100	6%	6%			25.7%	92.9%
California	799,470	855,780	7%	8%	✓		43.8%	93.1%
Colorado	106,280	108,360	7%	8%			40.8%	92.8%
Connecticut	49,130	47,750	5%	4%	✓		54.6%	96.2%
Delaware	7,350	9,160	3%	3%			49.1%	95.4%
District of Columbia	11,300	12,060	6%	6%	✓		69.1%	99.2%
Florida	300,050	361,960	6%	7%			41.4%	97.3%
Georgia	125,510	142,750	5%	5%			36.9%	93.3%
Hawaii	14,340	15,280	4%	4%			81.5%	99.9%
Idaho	31,620	34,640	8%	8%	✓	✓	41.1%	96.3%
Illinois	217,080	218,700	6%	6%			40.2%	95.7%
Indiana	70,760	90,520	4%	5%			35.5%	95.5%
Iowa	67,550	72,920	8%	8%	✓	✓	37.3%	97.4%
Kansas	66,500	59,970	8%	7%			41.4%	97.3%
Kentucky	70,360	63,550	6%	5%		✓	44.0%	92.4%
Louisiana	60,250	90,100	5%	6%		✓	34.9%	94.8%
Maine	20,620	18,900	5%	5%	✓	✓	42.7%	96.6%
Maryland	71,610	81,050	4%	5%			47.3%	96.7%
Massachusetts	92,400	107,550	5%	5%	✓	✓	56.2%	95.1%
Michigan	117,280	174,780	4%	6%	✓		50.3%	91.4%
Minnesota	138,630	134,620	8%	8%	✓	✓	42.9%	98.0%
Mississippi	33,910	39,030	4%	4%			28.4%	95.8%
Missouri	99,900	105,100	6%	6%			41.2%	92.3%
Montana	28,810	28,440	10%	10%			36.3%	94.7%
Nebraska	57,000	48,810	11%	9%			31.5%	94.8%
Nevada	33,000	35,820	5%	5%		✓	44.8%	96.0%
New Hampshire	13,150	15,050	3%	4%		✓	60.1%	99.6%
New Jersey	84,930	98,890	3%	4%	✓	✓	51.6%	94.4%
New Mexico	27,910	35,450	5%	6%		✓	37.6%	92.4%
New York	208,960	279,730	4%	5%	✓	✓	50.5%	98.6%
North Carolina	127,110	162,760	5%	6%	✓		43.1%	95.0%
North Dakota	23,570	20,890	12%	11%		✓	34.9%	96.3%
Ohio	129,610	136,690	4%	4%	✓		44.0%	98.5%
Oklahoma	50,930	46,770	5%	5%			32.0%	94.3%
Oregon	71,310	76,050	6%	7%	✓	✓	47.2%	98.0%
Pennsylvania	197,440	213,490	6%	6%	✓		54.4%	94.7%
Rhode Island	11,980	18,020	4%	5%	✓		55.4%	100.0%
South Carolina	62,830	58,430	5%	5%			39.9%	95.2%
South Dakota	24,120	23,900	11%	11%		✓	34.8%	91.9%
Tennessee	127,400	131,160	7%	7%			33.9%	95.2%
Texas	285,790	351,950	4%	5%			31.4%	96.1%
Utah	66,560	51,980	10%	8%	✓	✓	33.9%	96.0%
Vermont	12,840	11,440	7%	6%	✓	✓	46.1%	98.9%
Virginia	101,960	154,190	5%	7%	✓		47.7%	95.4%
Washington	110,560	132,410	6%	7%	✓	✓	45.9%	97.9%
West Virginia	15,730	17,380	3%	3%	✓		35.4%	97.5%
Wisconsin	122,960	111,970	7%	7%			44.0%	94.3%
Wyoming	13,660	13,790	9%	9%			31.9%	92.5%
United States	4,875,880	5,403,380	6%	6%	21	18	43.2%	95.4%

KEY:
Guaranteed Issue: *States receive a check if they require that insurers accept certain applicants for coverage regardless of health or risk status.*
Rating Restrictions: *States receive a check if they have policies that limit the extent to which insurers charge different premiums to different individuals.*

SOURCES:
 # and % of adults with Individual Coverage: Estimates based on 2004 and 2005 Current Population Survey data, available at http://www.statehealthfacts.org. In March 2007, the U.S. Census Bureau identified an error in the health coverage data produced by their Current Population Surveys from 1995-2005, which overstate the uninsured nationally by 0.6 percentage points. Data presented here reflect this error, although corrected data are expected after the publication date of this Issue Brief.
% of Private Sector Establishments Offering Insurance: Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, "2003 Medical Expenditure Panel Survey—Insurance Component," Table II.A.2, available at http://www.statehealthfacts.org.
Guaranteed Issue and Rating Restrictions: Kevin Lucia & Karen Pollitz, Georgetown University Health Policy Institute, 2005, available at http://www.statehealthfacts.org.

Appendix Table C: State Policies for Public Programs

State	# of Adults (19-64) with Medicaid		% of Adults (19-64) with Medicaid		Medicaid Income Eligibility Level for Parents at or above 100% of FPL *(see page 8)*	Public Insurance for Adults without Children *(see page 9)*
	Men	Women	Men	Women		
Alabama	80,540	138,080	6%	10%		
Alaska	14,170	17,300	7%	9%		
Arizona	121,110	199,040	7%	12%	✔	✔
Arkansas	45,950	71,330	6%	9%		
California	835,770	1,194,320	8%	11%	✔	
Colorado	45,870	80,060	3%	6%		
Connecticut	57,080	113,340	6%	10%	✔	
Delaware	12,890	23,420	5%	9%	✔	✔
District of Columbia	15,560	32,990	9%	17%	✔	✔
Florida	230,860	357,830	5%	7%		
Georgia	131,200	193,330	5%	7%		
Hawaii	18,660	28,650	5%	8%	✔	
Idaho	15,750	30,240	4%	7%		
Illinois	160,450	275,420	4%	7%	✔	✔
Indiana	78,090	142,200	4%	7%		
Iowa	35,390	64,460	4%	7%		
Kansas	29,490	53,320	4%	7%		
Kentucky	98,670	132,140	8%	10%		
Louisiana	68,080	115,220	5%	8%		
Maine	51,260	74,530	13%	18%	✔	
Maryland	49,390	76,250	3%	4%		
Massachusetts	186,780	232,330	9%	12%	✔	✔
Michigan	177,030	307,550	6%	10%		
Minnesota	81,990	117,460	5%	7%	✔	
Mississippi	77,160	96,970	9%	11%		
Missouri	99,420	164,070	6%	10%		
Montana	15,910	22,840	6%	8%		
Nebraska	14,200	33,200	3%	6%		
Nevada	17,450	35,540	2%	5%		
New Hampshire	4,870	13,270	1%	3%		
New Jersey	113,290	146,550	4%	5%	✔	
New Mexico	39,300	63,110	7%	11%		
New York	533,480	874,350	9%	15%	✔	✔
North Carolina	115,430	228,880	5%	9%		
North Dakota	8,320	13,770	4%	7%		
Ohio	132,160	337,970	4%	9%		
Oklahoma	35,160	62,580	4%	6%		
Oregon	56,970	94,030	5%	9%	✔	
Pennsylvania	195,790	320,880	5%	9%		
Rhode Island	30,500	46,950	10%	14%	✔	
South Carolina	80,530	128,010	7%	10%		
South Dakota	9,540	16,550	4%	7%		
Tennessee	178,720	284,350	10%	15%		
Texas	276,270	442,850	4%	7%		
Utah	25,380	44,630	4%	6%		
Vermont	21,160	27,280	11%	14%	✔	✔
Virginia	57,240	100,770	3%	4%		
Washington	97,960	190,570	5%	10%		
West Virginia	45,320	53,250	8%	10%		
Wisconsin	79,770	157,140	5%	9%		
Wyoming	5,610	8,990	4%	6%		
United States	5,366,670	8,387,630	6%	9%	15	7

KEY:
Medicaid Eligibility for Parents: *States receive a check if they provide coverage to parents at or above 100% of the federal poverty level.*
Public Insurance for Childless Adults: *States receive a check if they provide comprehensive coverage to childless, nondisabled, nonelderly adults up to a specific income level, without an enrollment gap.*

SOURCES:
 # and % of adults with Medicaid: Estimates based on 2004 and 2005 Current Population Survey data, available at http://www.statehealthfacts.org. In March 2007, the U.S. Census Bureau identified an error in the health coverage data produced by their Current Population Surveys from 1995-2005, which overstate the uninsured nationally by 0.6 percentage points. Data presented here reflect this error, although corrected data are expected after the publication date of this Issue Brief.
Medicaid Eligibility for Parents *and* Public Insurance for Childless Adults: Data collected by the National Women's Law Center, March 2006.

The National Women's Law Center is a nonprofit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families, including employment, education, health and reproductive rights, and family economic security.

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